IPRO

Better healthcare, realized.

New Jersey Department of Human Services
Division of Medical Assistance and Health Services
CORE MEDICAID and MLTSS
External Quality Review
Annual Technical Report
Review Period: January 1, 2022–December 31, 2022
(2022–2023 Reporting Cycle)

Table of Contents

I. EXECUTIVE SUMMARY 5

Purpose of Report 5
Scope of External Quality Review Activities Conducted 5
High-Level Program Findings and Recommendations 7
Conclusion and MCO Recommendations 13

II. NEW JERSEY MEDICAID MANAGED CARE PROGRAM 14

Managed Care in New Jersey 14
New Jersey – 2022 State Initiatives 16
New Jersey DMAHS Quality Strategy 24

III. VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS 27

Objectives 27
Technical Methods of Data Collection and Analysis 29
Description of Data Obtained 30
Conclusions and Comparative Findings 30

IV. REVIEW OF COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS 63

Objectives 63
Technical Methods of Data Collection and Analysis 63
Description of Data Obtained 64
Conclusions and Comparative Findings 65

V. VALIDATION OF PERFORMANCE MEASURES 71

Objectives 71
Technical Methods of Data Collection and Analysis 71
Description of Data Obtained 71

VI. ADMINISTRATION OR VALIDATION OF QUALITY OF CARE SURVEYS – CAHPS MEMBER EXPERIENCE SURVEY 91

Objectives 91
Technical Methods of Data Collection and Analysis 91
Description of Data Obtained and Conclusion 91
Conclusions and Comparative Findings 92

VII. CARE MANAGEMENT AUDITS 94

2022 Core Medicaid Care Management Audits 94
Core Medicaid Care Management and Continuity of Care Annual Assessment 95
2022 MLTSS Nursing Facility Care Management Audits 97
2022 MLTSS HCBS Care Management Audits 107
Return to Field MLTSS HCBS Focus Study 114
MLTSS 2022 Care Management and Continuity of Care Annual Assessment 115

VIII. FOCUS STUDIES OF HEALTH CARE QUALITY 117

2022 Prenatal and Postpartum Focus Study 117

IX. ENCOUNTER DATA VALIDATION 118

X. MCO RESPONSES TO THE PREVIOUS EQR RECOMMENDATIONS 119

ABHNJ Response to Previous EQR Recommendations 119
AGNJ Response to Previous EQR Recommendations 137
HNJH Response to Previous EQR Recommendations 144
UHCCP Response to Previous EQR Recommendations 151
WCHP Response to Previous EQR Recommendations 158

XI. MCO STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 165

ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations 165
AGNJ – Strengths and Opportunities for Improvement, and EQR Recommendations 167

HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations 170
UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations 172
WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations 174

APPENDIX A: JANUARY 2022 – DECEMBER 2022 NJ MCO-SPECIFIC REVIEW FINDING 177

APPENDIX B: ABHNJ 2022 CORE MEDICAID AND MLTSS CARE MANAGEMENT AUDITS 177

APPENDIX C: AGNJ 2022 CORE MEDICAID AND MLTSS CARE MANAGEMENT AUDITS 177

APPENDIX D: HNJH 2022 CORE MEDICAID AND MLTSS CARE MANAGEMENT AUDITS 177

APPENDIX E: UHCCP 2022 CORE MEDICAID AND MLTSS CARE MANAGEMENT AUDITS 177

APPENDIX F: WCHP 2022 CORE MEDICAID AND MLTSS CARE MANAGEMENT AUDITS 177

APPENDIX G: SUPPLEMENTAL DOCUMENTS – SUBMISSION GUIDES FOR 2022 ANNUAL ASSESSMENT REVIEW AND 2022 CARE MANAGEMENT AUDITS (CORE MEDICAID AND MLTSS) 177

List of Tables

Table 1: December 2021–December 2022 Medicaid MCO Enrollment 14
Table 2: 2022 EQR Activities by MCO 15
Table 3: NJ DMAHS Quality Strategy Goals 24
Table 4: Core Medicaid and MLTSS PIP Topics 27
Table 5: PIP Validation Scoring and Compliance Levels 30
Table 6: PIP State Topic #1: Core Medicaid Adolescent Risk Behaviors and Depression 31
Table 7: PIP State Topic #2: Core Medicaid Primary Care Providers Access and Availability 34
Table 8: PIP State Topic # 3: Core Medicaid EPSDT Well Child Visits, Childhood Immunizations 37
Table 9: PIP State Topic # 4: MLTSS Gaps in Care 40
Table 10: PIP State Topic # 5: MLTSS Fall Prevention 43
Table 11: PIP State Topic #6: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population 46
Table 12: 2022 PIP Validation Results 49
Table 13: MCO PIP Results – Core Medicaid Adolescent Risk Behaviors and Depression Collaborative (2018–2022) 50
Table 14: PIP Interventions Summary 2021–2022 for Adolescent Risk Behaviors and Depression 51
Table 15: PIP Interventions Summary 2021–2022 for Access and Availability 53
Table 16: PIP Interventions Summary 2021–2022 for EPSDT: Increasing Early and Periodic Screening Diagnostic and Treatment Visits and Childhood Immunizations 55
Table 17: PIP Interventions Summary 2021–2022 for Gaps in Care in the MLTSS Population 57
Table 18: PIP Interventions Summary 2021–2022 for Falls Prevention (Only 1 MCO) 59
Table 19: PIP Interventions Summary 2021–2022 for Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations 60
Table 20: 2022 Annual Assessment Type by MCO 63
Table 21: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation 65
Table 22: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standards 65
Table 23: Subpart D and QAPI Standards – Scores by MCO 66
Table 24: Comparison of 2021 and 2022 Compliance Scores by MCO 68
Table 25: 2021 and 2022 Compliance Scores by Review Category 68
Table 26: MCO Compliance with Information System Standards – MY 2021 71
Table 27: Information Systems Capabilities Assessment (ISCA) Results for 2020 72
Table 28: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass National Percentiles 75
Table 29: HEDIS MY 2021 Performance Measures 75
Table 30: MY 2021 NJ State-Specific Performance Measures 81
Table 31: MY 2021 NJ Core Set Measures 83
Table 32: MLTSS Service Delivery Sample Summary 89
Table 33: Rate of Service Delivery Versus Planned Amount 89
Table 34: Results of Performance Measures 90
Table 35: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2021 Quality Compass National Percentiles 92
Table 36: CAHPS MY 2021 Performance – Medicaid Adult Survey 92
Table 37: CAHPS MY 2021 Performance – Medicaid Child Survey 93

TABLE 38: CORE MEDICAID CARE MANAGEMENT SUMMARY OF PERFORMANCE 95
TABLE 39: SUMMARY OF FINDINGS FOR 2022 CORE MEDICAID CARE MANAGEMENT AND CONTINUITY OF CARE 96
TABLE 40: SUMMARY OF FINDINGS FOR CORE MEDICAID CARE MANAGEMENT AND CONTINUITY OF CARE 96
TABLE 41: MLTSS NF/SCNF POPULATION SUBGROUPS 98
TABLE 42: 2022 MLTSS NF/SCNF AUDIT RESULTS 99
TABLE 43: RESULTS OF MLTSS NF/SCNF PERFORMANCE MEASURES – JANUARY 1, 2021 – AUGUST 14, 2021 102
TABLE 44: SAMPLING METHODOLOGY 108
TABLE 45: 2022 MLTSS HCBS RESULTS BY CATEGORY 110
TABLE 46: 2022 MLTSS HCBS PERFORMANCE MEASURES 113
TABLE 47: RATING SCALE FOR THE MCO (MLTSS) ANNUAL ASSESSMENT REVIEW OF CARE MANAGEMENT 116
TABLE 48: COMPLIANCE SCORES BY MCO FOR THE 2022 MLTSS CARE MANAGEMENT AND CONTINUITY OF CARE ANNUAL ASSESSMENT ELEMENTS 116
TABLE 49: SUMMARY OF FINDINGS FOR MLTSS CARE MANAGEMENT AND CONTINUITY OF CARE 116
TABLE 50: ABHNJ RESPONSE TO PREVIOUS EQR RECOMMENDATIONS 119
TABLE 51: AGNJ RESPONSE TO PREVIOUS EQR RECOMMENDATIONS 137
TABLE 52: HNJH RESPONSE TO PREVIOUS EQR RECOMMENDATIONS 144
TABLE 53: UHCCP RESPONSE TO PREVIOUS EQR RECOMMENDATIONS 151
TABLE 54: WCHP RESPONSE TO PREVIOUS EQR RECOMMENDATIONS 158
TABLE 55: ABHNJ – STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 165
TABLE 56: AGNJ – STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 167
TABLE 57: HNJH – STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 170
TABLE 58: UHCCP – STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 172
TABLE 59: WCHP – STRENGTHS AND OPPORTUNITIES FOR IMPROVEMENT, AND EQR RECOMMENDATIONS 174

List of Figures

FIGURE 1: DECEMBER 2021 – DECEMBER 2022 MEDICAID MANAGED CARE ENROLLMENT BY MCO 15
FIGURE 2: MCO COMPLIANCE SCORES BY YEAR (2020–2022). 69

I. Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR Section § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), contracted with IPRO, an EQRO, to conduct the 2022 EQR activities (reporting cycle 2022-2023) for five MCOs contracted to furnish Medicaid services in the state. During the period under review, January 1, 2022–December 31,2022, DMAHS's participating NJ FamilyCare Managed Care MCOs included Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and WellCare Health Plans of New Jersey, Inc. (WCHP). As per DMAHS, enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long-Term Services and Supports (MLTSS) was 2,158,966 as of 12/31/2022. This report presents aggregate and MCO-level results of these EQR activities for ABHNJ, AGNJ, HNJH, UHCCP and WCHP.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the three mandatory and four optional EQR activities that were conducted. External quality review (EQR) activities conducted during January 2022–December 2022 included annual assessment of MCO operations, performance measure (PM) validation, validation of performance improvement projects (PIPs), focus studies, which include Core Medicaid care management (CM) audits, and MLTSS CM audits, encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and calculation of additional performance measures.

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

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

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Optional Protocol 5:* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality of Care Surveys –** In 2022, two satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.
- ***CMS Optional Protocol 7:* Calculation of Additional Performance Measures –** This activity specifies that the external quality review organization (EQRO) may calculate performance measures in addition to those specified by the state for inclusion in MCOs' QAPI programs.
- ***CMS Optional Protocol 8:* Implementation of Additional Performance Improvement Projects –** This activity validates that additional MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality –** This activity conducts clinical and non-clinical focus studies to assess quality of care at a point in time.

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

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

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

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. A full ISCA was conducted with each NJ MCO in 2020. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in **Section V: Validation of Performance Measures**.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2021–2022 EQR activity findings to assess the performance of New Jersey Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

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

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted from January 1, 2022, through December 31, 2022, demonstrated that DMAHS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members. The opportunities for improvement and recommendations relating to quality of, timeliness of, and access to care are outlined here and detailed in each corresponding section of this report.

Performance Improvement Projects

For January 2022–December 2022, this Annual Technical Report (ATR) includes IPRO's evaluation of the April 2022 PIP updates, August 2022 PIP report submissions, and final PIP submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Full validation results for the Core Medicaid and MLTSS 2022 PIPs are described in **Section III: Validation of Performance Improvement Projects**.

Core Medicaid:

The following three (3) Core Medicaid PIPs were conducted by the MCOs during the ATR review period. Two Core Medicaid PIPs are clinical and one PIP is non-clinical. One clinical PIP was completed in August 2022:

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

MLTSS:

The following three (3) MLTSS PIPs were conducted by the MCOs during the ATR review period. Two clinical PIPs were completed in August 2022.

1. One (1) MCO (AGNJ) was engaged in a MLTSS PIP topic relating to Falls Prevention (August – Final Report)
2. All five (5) MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) were engaged in an MLTSS PIP topic relating to Gaps in Care (August – Final Report)
3. All five (5) MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) are also engaged in an MLTSS PIP for the topic regarding Improving Coordination of Care Following Up Mental Health Hospitalization (August – Project Status Reports Submission – Baseline Report and Project Year 1 Update)

Comprehensive Administrative Review (2022 Annual Assessment of MCO Operations)

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

In 2022, due to the continued impact of the 2019 novel coronavirus (COVID-19) pandemic, the Annual Assessment audits were conducted remotely. For the review period July 1, 2021–June 30, 2022, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. In 2022, the average compliance score for five standards (Access, Quality Management, Programs for the Elderly and Disabled, Satisfaction, and Utilization Management) showed increases ranging from 1 to 9 percentage points. In 2022, five standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Satisfaction, Utilization Management, and Management Information Systems) had an average score of 100%. Average compliance for three standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, and Management Information Systems) remained the same from 2021 to 2022. Five standards (Committee Structure, Provider Training and Performance, Enrollee Rights and Responsibilities, Credentialing and Recredentialing, and Administration and Operations) decreased 1 to 4 percentage points from 2021 to 2022. Access had the lowest average compliance score at 79%. Findings from this review can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

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. Of the 239 elements reviewed during the Annual Assessment, 81 crosswalk to the CMS QAPI Standards. The crosswalk of the individual elements reviewed during the Annual Assessment to the CMS QAPI Standards can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

MY 2021 New Jersey HEDIS Performance Measures

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

The NJ FamilyCare Managed Care Contract article 4.6.2.P requires NJ FamilyCare MCOs to report annually on Healthcare Effectiveness Data and Information Set (HEDIS®) PMs and ambulatory care utilization measures. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate those measures. Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS final audit report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA.

Notable HEDIS Measure Changes from MY 2020 to MY 2021

1. Childhood Immunization (CIS) has Combination 3, 7 and 10 as submeasures comparing to last year Combination 2, 3 and 9.

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

Overall, most measures remained constant from MY 2020 to MY 2021 (< 5 percentage point change). Significant improvement (≥ 5 percentage point change) in performance from MY 2020 to MY 2021 were noted for one or more rates of Comprehensive Diabetes Care (CDC), Controlling High Blood Pressure (CBP), Prenatal and Postpartum Care (PPC), Appropriate Treatment for Upper Respiratory Infection (URI), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing, Asthma Medication Ratio (AMR), and Annual Dental Visits (ADV). Significant declines (≥ 5 percentage point change) in

performance from MY 2020 to MY 2021 were noted for one or more rates for Lead Screening in Children (LSC), Appropriate Testing for Pharyngitis (CWP), Follow-Up Care for Children Prescribed ADHD Medication (ADD), and Follow-Up After Hospitalization for Mental Illness (FUH).

MY 2021 New Jersey State-Specific Performance Measures and Core Set Measures

Measures reported for MY 2021 by the MCOs can be categorized as follows:

There are two required New Jersey Specific Performance Measures:

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

There are four Child Core Set Measures:

1. Developmental Screening in The First Three Years of Life (DEV-CH)
2. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
3. Contraceptive Care Postpartum Women ages 15-20 (CCP-CH)
4. Contraceptive Care All Women ages 15-20 (CCW-CH)

There are three Adult Core Set Measures:

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

The changes from MY 2020 to MY 2021 are:

1. Screening for Depression and Follow-Up Plan: Ages 12 to 17 was added.

All five MCOs had an increase in performance for the Preventive Dental measure. Overall performance for all five MCOs declined for Multiple Lead Testing in Children- Screening between 9 months and 18 months measure. Admission rates for Diabetes Short-Term complications declined. Details of these results can be found in **Section V: Validation of Performance Measures**.

MLTSS Performance Measure Validation

WYE 2022 refers to the period July 1, 2021, through June 30, 2022.
WYE 2023 refers to the period July 1, 2022, through June 30, 2023.

Activities conducted during CY 2022 included validation of measures for both WYE periods, due to the lag time for reporting some claims based and HEDIS based measures, and updating and establishing specifications for all MLTSS PMs for WYE 2023.

All MLTSS PMs are validated annually. IPRO reviews source code, member level files, and rates for each MCO, PM #04 is reported on a monthly basis. Four HEDIS measures and one MLTSS specific measure (PM #47) are reported annually. All other PMs are reported on a quarterly and annual cycle. PM #20a was retired in 2021.In addition to annual validation of all PMs, IPRO monitored all ongoing reporting to the state on a quarterly basis. Note: In the course of validating WYE 2022 PMs, an issue was identified with population definition for WellCare Health Plan. This issue impacted both WYE 2022 rates and previously submitted rates for WYE 2021. Final validation of WYE 2022 and restatement of rates for WYE 2021 is still ongoing. A list of all MLTSS performance measures validated in WYE 2022 and WYE 2023 can be found in **Section V: Validation of Performance Measures.**

2022 MLTSS Performance Measure #13

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

In 2022, the validation of PM #13 for measurement period from July 2020 to June 2021 continued. For the measurement period July 2020 to June 2021, Members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2020, and June 30, 2021. The final PM #13 reports by MCO are ongoing and results will be reflected in the next ATR in 2024 as noted in **Section V: Validation of Performance Measures**.

2022 MLTSS Service Delivery Project

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

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

In 2022, the MLTSS Service Delivery project was based on the measurement period July 1, 2020, through December 31, 2020. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 and was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. IPRO developed an algorithm, to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

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

Although the final report is ongoing, each MCO reviewed, and approved the rates for the 2022 MLTSS Service Delivery Project. Preliminary results for this project by MCO can be found in **Section V: Validation of Performance Measures**. Final report findings, including any changes to the preliminary rates, will be presented in the next ATR in 2024.

Information Systems Capabilities Assessment

In 2016, CMS issued the Medicaid and CHIP Final Rule. In accordance with the 2016 Final Rule, CMS updated the External Quality Review (EQR) protocols, which were released in 2019. The updated protocols indicated that an Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR for Protocols 1 (Validation of Performance Improvement Projects), 2 (Validation of Performance Measures), 3 (Review of Compliance with Medicaid and CHIP Managed Care Regulations), and 4 (Validation of Network Adequacy). The five Medicaid MCOs in New Jersey use HEDIS certified software and submit audited HEDIS results to the state of New Jersey. However, some measures, such as non-HEDIS Core set measures, measures associated with Managed Long-Term Services and Supports (MLTSS), and New Jersey specific measures for Medicaid, are produced outside of the HEDIS audit. While CMS has clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA, DMAHS determined that all five MCOs should undergo an ISCA as part of the scheduled Annual Assessment of Compliance with Medicaid Managed Care regulations. The ISCAs were conducted by IPRO in 2020.

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

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 addition to the annual review of information systems (IS) that is conducted during the annual HEDIS review for each MCO in New Jersey, the Annual Assessment review conducted by IPRO for each organization includes review of 18 separate elements. Review of the IS elements includes live demonstration of systems.

Quality of Care Surveys

Member Satisfaction – 2022 CAHPS Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health Plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide Children's Health Insurance Program (CHIP) only survey. All of the members surveyed required continuous enrollment from July 1, 2021, through December 31, 2021, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey. Details on these surveys can be found in **Section VI: Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey**.

Focus Studies

2022 Prenatal and Postpartum Care Focus Study

In 2022, at the request of DMAHS, IPRO developed a clinical focus study on prenatal and postpartum care. This is a descriptive study whose aim is to identify sociodemographic disparities in the access and availability of prenatal and postpartum care among Medicaid beneficiaries in New Jersey as measured by the HEDIS PPC measure.

In 2023, the study is currently underway. IPRO will provide the final report to DMAHS and study findings will be presented in the next Annual Technical Report. See **Section VIII: Focus Studies of Health Care Quality**.

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 2022, IPRO continues to monitor encounter data submissions and patterns. Study findings can be found in **Section IX: Encounter Data Validation** of this report.

Care Management Audits

2022 Core Medicaid Care Management Audits

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

In 2022, IPRO and OQA collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process.

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

The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, up to 300 DDD, DCP&P and GP charts are reviewed for each MCO. The actual number of charts reviewed is dependent upon the population size that meets the sample criteria for audit. In addition to the Core Medicaid Care Management chart review audit, in 2022 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The Annual Assessment of the Care Management and Continuity of Care standard covered the period from January 1, 2021, to December 31, 2021. There are 30 contractual provisions under review. Interviews with the MCOs were held with key MCO staff via WebEx in May 2022. Overall compliance scores for the five MCOs ranged from 73% to 83% in 2022. Results of this review can be found in **Section VII: Care Management Audits**.

2022 MLTSS HCBS Care Management Audits

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19

pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management Activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance. Results of this review can be found in **Section VII: Care Management Audits.**

Return to Field MLTSS HCBS Focus Study

In 2022, at the request of DMAHS, in conjunction with the 2022 MLTSS HCBS audit, IPRO developed a focus study on the Return to Field for the Managed Long Term Services and Supports (MLTSS) and Home and Community Based Services (HCBS) population to evaluate the MCO's compliance with the Department of Medical Assistance and Services (DMAHS) Return to Field guidance dated August 11, 2021. The study is currently underway. IPRO will provide the final report to DMAHS and study findings will be presented in the next Annual Technical Report. See **Section VII: Care Management Audits.**

2022 MLTSS Nursing Facility Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30. Due to COVID-19, the prior review period was from July 1, 2019, through February 29, 2020. An expansion period was included from March 1, 2020, through December 31, 2020, to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was January 1, 2021, through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Results of this review can be found in **Section VII: Care Management Audits**.

Conclusion and MCO Recommendations

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

II. New Jersey Medicaid Managed Care Program

Managed Care in New Jersey

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. Per DMAHS, as of December 2022 there were approximately 2,158,966 individuals enrolled in Medicaid Managed Care (MMC) and the number increased from 2,017,540 in December 2021 (**Table 1**). Of the 2,158,966 individuals enrolled in MMC, 65,861 were receiving MLTSS services as of December 2022. More than 96% of managed care eligible beneficiaries receive services through the managed care program (data not shown).

In the fall of 2021, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) submitted an application to the federal Centers for Medicare and Medicaid Services (CMS) to renew the New Jersey FamilyCare Comprehensive Demonstration. This demonstration, authorized under Section 1115 of the Social Security Act, governs the operations of significant components of New Jersey's Medicaid program and Children's Health Insurance Program (CHIP). This demonstration is currently in its second five-year performance period, which, after two extensions, is scheduled to expire on January 31, 2023.

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

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

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in December 2021–December 2022. **Table 1** presents respective enrollment figures in December 2021 and December 2022.

Table 1: December 2021–December 2022 Medicaid MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2021	December 2022	December 2021	December 2022
Aetna Better Health of New Jersey	ABHNJ	124,882	139,597	5,265	5,963
Amerigroup New Jersey, Inc.	AGNJ	255,447	266,927	9,835	10,978
Horizon NJ Health	HNJH	1,129,000	1,218,011	21,677	22,684
UnitedHealthcare Community Plan	UHCCP	401,147	420,685	9,676	12,561
WellCare Health Plans of New Jersey, Inc.	WCHP	107,064	113,746	12,613	13,675
Total		**2,017,540**	**2,158,966**	**59,066**	**65,861**

[1] Managed Long-Term Services and Supports (MLTSS) members are included in the December 2021–2022 Medicaid enrollment figures.
Source: DMAHS

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid including MLTSS-eligible enrollment for December 2021 and December 2022 in relation to the entire NJ MMC population.

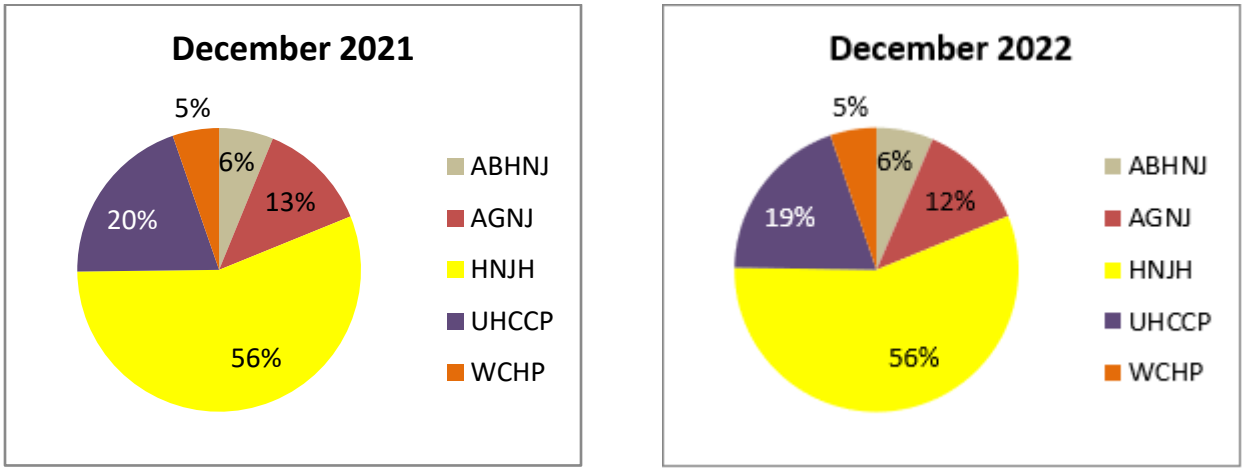


Figure 1: December 2021 – December 2022 Medicaid Managed Care Enrollment by MCO
Enrollment in MMC for each MCO reported as of December 2021 (left panel) and December 2022 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (grey); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (yellow); UHCCP: UnitedHealthcare Community Plan (purple); WCHP: WellCare Health Plans of New Jersey, Inc. (orange). Percentages may not add to 100% due to rounding.

Table 2 shows the activities discussed in this report and the MCOs included in each EQR activity.

Table 2: 2022 EQR Activities by MCO

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

EQR: External Quality Review; MCO: Managed Care Organization; PM: Performance Measure; MLTSS: Managed Long-Term Services and Supports; PIP: Performance Improvement Project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: Care Management; HCBS: Home and Community Based Services; NF: Nursing Facility; ISCA: Information Systems Capabilities Assessment [1] A full ISCA was conducted in 2020. HEDIS IS assessments are conducted every year including 2022.

New Jersey – 2022 State Initiatives

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

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

1115 Renewal Proposal

In the fall of 2021, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) submitted an application to the federal Centers for Medicare and Medicaid Services (CMS) to renew the New Jersey FamilyCare Comprehensive Demonstration. This demonstration, authorized under Section 1115 of the Social Security Act, governs the operations of significant components of New Jersey's Medicaid program and Children's Health Insurance Program (CHIP). This demonstration is currently in its second five-year performance period, which, after two extensions, is scheduled to expire on January 31, 2023.

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

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

- **Maintaining momentum on existing demonstration elements:**
  - o Continue improvements in quality of care and efficiency associated with managed care; improve access to critical services in the community through Managed Long-Term Services and Supports (MLTSS) and other home and community based services programs; and create innovative service delivery models to address substance use disorders.
  - o Update existing demonstration terms and conditions to address implementation challenges, and accurately capture how the delivery system has evolved in New Jersey over the past several years.

- **Expand our ability to better serve the whole person:**
  - o Test new approaches to addressing the social determinants of health, with a particular emphasis on housing-related issues.
  - o Encourage greater integration of behavioral and physical health, and continued availability of appropriate behavioral health services for all Medicaid beneficiaries.

- **Serve our communities the best way possible:**
  - o Address known gaps and improve quality of care in maternal and child health.
  - o Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity).

New Jersey continues to work with our federal partners at CMS to finalize the Demonstration Renewal and expect to have approval early in 2023.

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

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

Per CMS guidance, New Jersey has submitted and received conditional partial CMS approval for an initial spending plan, outlining our HCBS funding priorities. This plan has since been updated quarterly. New Jersey's proposed investment plan seeks to strengthen existing robust HCBS offerings, while making new investments to maintain beneficiaries' access to high-quality community-based care, and addressing the ongoing effects of the COVID-19 public health emergency.

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

This spending plan lasts until March of 2025 and through the quarterly update process, New Jersey continues to work with CMS to receive approval of outstanding activities, implement already approved activities, and update budget assumptions.

Electronic Visit Verification

Electronic Visit Verification Section 12006(a) of the 21st Century Cures Act (Cures Act) mandates that states implement electronic visit verification (EVV) for Personal Care Services (PCS) and Home Health Care Services (HHCS). In compliance with this mandate, DMAHS' EVV aggregation vendor provides a centralized web-based EVV system using the Open Vendor Model based on stakeholder feedback and preferences.

In accordance with the Cures Act, Personal Care Services utilize EVV to capture required data elements. The State's EVV system assures that services are prior authorized and delivered by the provider according to members' assessed needs. The State utilizes the data to monitor and ensure that applicable services are EVV compliant. Additionally, the data is used for reporting quarterly Key Performance Indicators (KPI) to the Centers for Medicare and Medicaid Services (CMS).

Collaboration, training, and communication with stakeholders, providers, members, and families continue as the state prepares for EVV implementation of Home Health Care Services on January 1, 2023.

Health Information Technology and the Medicaid Enterprise System

The Division of Medical Assistance & Health Services (DMAHS) continues to put health information technology (HIT) at the forefront, supporting initiatives that promote interoperability to reduce healthcare costs, and improve care coordination and administrative efficiencies. The COVID-19 pandemic has cast a spotlight on the importance of interoperability and health information sharing during the public health emergency. While the

pandemic has also exposed the gaps between disparate health systems, it has also presented several areas of opportunity to grow the health information technology infrastructure of the state Health Information Exchange (HIE) for better care coordination and improved patient health outcomes.

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid, including the establishment of an overall Medicaid Enterprise System (MES) strategy, that encompasses IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E), and continuation of programs and systems developed through the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the CMS's conditions for enhanced funding and ensure that technology investments enable the fulfillment of programmatic goals while creating efficiencies from utilizing modern technology. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Management Information System (MMIS)

DMAHS continues with modernization initiatives for the MMIS (MMIS-M), which is a key component in the operation of DMAHS programs for providing comprehensive health coverage to over 2 million New Jersey residents. While the COVID-19 public health emergency (PHE) along with preparations for the PHE unwinding were a major focus in FFY 2022, DMAHS made strides in MMIS modernization efforts and was able to:

- Maintain operational stability and service delivery;
- Successfully obtain final CMS certification of the electronic visit verification management system (EVVMS) based on the Outcomes-Based Certification (OBC) protocol;
- Configure the EVVMS for timely compliance with the EVV mandate for home health care services (HHCS) in advance of the January 1, 2023 deadline specified by the 21st Century Cures Act;
- Complete the Member Operational Data Store (Member ODS) Pilot with expected results, and finish the production server configuration and database creation;
- Refine the Provider Operational Data Store (Provider ODS) roadmap to address priority business use cases and develop the baseline Logical Data Model (LDM) to reflect legacy system data sources;
- Resume preparations for the procurement of the Provider Management Module and receive approval from the state Office of Information Technology (OIT) for the Technology Initiation Proposal (TIP);
- Complete four (4) proof of concept (PoC) exercises with the legacy MMIS vendor preparatory to the implementation of the pilot integration platform, which will serve as the nexus between the legacy system and the new provider management module;
- Complete the Shared Data Warehouse (SDW) implementation of HealthFocus, which uses a newer web application and a cloud hosted solution;
- Socialize key concepts of the Scaled Agile Framework;
- Complete the procurement of project management services to support successful project implementation and quality execution; and
- Transition end-of-life legacy system components to newer and more secure hardware and software to preserve key functionalities for operational needs.

DMAHS has also prioritized data completeness and quality to support TMSIS reporting. To this end, a concerted effort involving collaboration among cross-functional disciplines from policy, technical, and

operations units has effectively addressed outstanding issues identified from the Outcomes Based Assessment (OBA) and brought DMAHS to a blue status that indicates fulfillment of OBA targets.

DMAHS will continue to refine its MMIS modernization roadmap to ensure alignment with program goals and priorities and utilize an outcomes-focused investment strategy.

NJ FamilyCare Integrated Eligibility System

New Jersey continued leadership in the cloud-based eligibility system field through enhancements and improvements to the NJ FamilyCare Integrated Eligibility System (IES). Utilizing agile methodology and modularity in the development and implementation, the state is able to deliver services in a timely and cost effective manner, while reducing the overall risk associated with traditional software development. Using a cloud-based solution, New Jersey continued enhancing the online applications for Modified Adjusted Gross Income (MAGI), Aged, Blind and Disabled (ABD), and Presumptive Eligibility (PE) programs. The online application is used by citizens, county workers, assistors, and health benefits coordinators. Along with the online application, New Jersey continued enhancing the online worker portal that enables county workers to complete eligibility determinations. The worker portal automates verification, MAGI and non-MAGI eligibility determination, and NJ FamilyCare program determination.

The MAGI in the Cloud software service, designed and maintained by CMS and operated through New England States Consortium Systems Organization (NESCSO), is used to automate MAGI eligibility determination. This service allows all NJ MAGI eligibility and program determinations to be done consistently using one set of rules. NJ FamilyCare is configured to interface with the Federal Data Services Hub (FDSH) for verifications. Through the FDSH, the Social Security Administration (SSA), Verify Lawful Presence (VLP), and Equifax Income, verifications have all been implemented. In November 2020, Get Covered New Jersey, the state's official health insurance marketplace, was implemented and DMAHS continues to support the integration and Account Transfers during and beyond the open enrollment period.

During the COVID-19 public health emergency, NJ FamilyCare IES rapidly made system enhancements in order to accommodate urgently needed policy updates to address the beneficiaries' needs in the PHE, while at the same time expanding functionality to all modules of the system. Some of these enhancements and module deployment include:

- Launching an ABD Assistor Portal that allows approved and registered Medicaid ABD providers to more easily submit multiple ABD applications;
- Upgrades to automated notices and online applications;
- Enhancements to Verify Lawful Presence (VLP) verifications;
- Expanding Medicaid Eligibility System (MES) automatic upload functionality to ABD new applications;
- Full county deployment of electronic MAGI Renewals and Redeterminations;
- Continuing design and development phases of the MES Modernization project, which will move all core eligibility functions into NJ FamilyCare IES;
- Deployment of Extended Post-Partum coverage.

These NJ FamilyCare IES functionalities will only continue to improve eligibility determination processing time in order to provide for the healthcare needs of the most vulnerable beneficiaries in the state. In the coming year, New Jersey Eligibility and Enrollment effort will be focused on several high priority projects, including the PHE unwind activities. The goal is to ensure that ~2.1 million beneficiaries are properly renewed or referred to make certain that health coverage is made available to those in need of service.

Health Information Technology

The HITECH/ Medicaid Promoting Interoperability Programs administered by DMAHS (from 2011 through 2021) has catalyzed health information technology adoption in the healthcare settings across New Jersey. Despite the complex demands of the program, most professional practices and hospitals statewide have implemented certified Electronic Health Record technology and more information is being shared electronically. New Jersey Health Information Network (NJHIN), the state health information exchange (HIE) infrastructure, has also been an integral part of the HITECH program, with the goal to advance interoperability and improve care coordination. DMAHS leveraged CMS funding to support the administrative needs of the Medicaid Promoting Interoperability Program, as well as to support the development of the NJHIN and associated HIE use cases. DMAHS also ensured a successful program sunset by the end of FFY 2022 in accordance to the CMS guidance.

As the HITECH Act funding expired, the CMS offered states the opportunity to continue health information exchange efforts through the Medicaid Enterprise Systems (MES) funding streams for the sustainability of efficient and effective Medicaid operations. DMAHS, along with its HIE partners, are preparing for streamlined modular and outcomes based certification of NJHIN as part of the Medicaid enterprise. Once certified, New Jersey Medicaid will be able to request for federal match for operational support of NJHIN. The certification for NJHIN is planned to be received by the end of Q1 2023. DMAHS is also assisting the Division of Consumer Affairs (DCA) to certify the New Jersey Prescription Monitoring Program (NJPMP) for the continued operations funding as part of the Medicaid Enterprise. The NJPMP is an important tool in addressing the opioid crisis by halting the abuse and diversion of controlled prescription medications. The certification for NJPMP is planned to be received by the end of Q2 2023.

Additionally, DMAHS continues efforts to encourage the adoption of HIT among the substance use disorder (SUD) providers, with the goal to improve care coordination and integration among behavioral health and physical health. As of November 2022, there are 90 SUD facilities that are qualified and registered for the program. A total of $1.8 million in milestone payments have been disbursed to 82 SUD facilities that successfully achieved milestones 1 through 4. New Jersey's SUD Promoting Interoperability Program has maintained leadership in the behavioral health information technology field by the reuse of the Medicaid Promoting Interoperability program's attestation system, and has continued to receive invitations to present the program information in several HIT conferences and federal meetings, including CMS and the Medicaid and CHIP Payment and Access Commission.

Quality Improvement Program– New Jersey (QIP-NJ)

In conjunction with DMAHS, The Department of Health continues its administration of the QIP-NJ program, a hospital pay-for-performance initiative that launched in 2021. QIP-NJ has a dual focus of quality improvement with maternal health and behavioral health components. In 2022, sixty acute care hospitals were participating in Year 2 of a proposed 5-year program—with forty-eight participating in the maternal health component and fifty-six participating in the behavioral health component. For more information, please see https://qip-nj.nj.gov/.

Maternal Health

Aligning with the NurtureNJ campaign of First Lady Tammy Murphy, New Jersey continues its work towards improving the state's maternal and infant health outcomes—with a focus on reducing racial disparities. New Jersey's 2022 maternal health initiatives include:

- Expanding postpartum coverage: NJ FamilyCare expanded postpartum coverage to 365 days after the end of a pregnancy (an increase from 60 days postpartum). This expansion is intended to promote continuity

of care and ensure that individuals have access to high-quality healthcare during the critical postpartum period.

- Supporting maternity-related care: Starting in July 2022, NJ FamilyCare increased fee-for-service reimbursement rates for certain maternity-related services for physician specialists, midwives, and community doulas. These increases are intended to make sure our rates are competitive to retain and recruit high quality perinatal clinicians and community doulas.
- Supporting midwifery care: Starting in May 2022, NJ FamilyCare allowed all midwives licensed in New Jersey—not only certified nurse-midwives—to enroll as providers and deliver care to our members. Starting in July 2022, NJ FamilyCare now reimburses fee-for-service midwifery care at 100% of the physician specialist rate (an increase from 95% of the physician non-specialist rate). These changes are intended to promote access to midwifery care.
- Piloting innovation in quality improvement: In April 2022, NJ FamilyCare launched the first Performance Period of its perinatal episode of care pilot. The program is a three-year pilot to test a new alternative payment for prenatal, labor, and postpartum services statewide. Its goal is to improve the quality of maternity care by incentivizing obstetrical providers to broadly engage in all aspects of their patient's care. Initially, sixteen hospital-affiliated and community practices that provide care for 10,000 Medicaid births statewide annually chose to participate in Performance Period 1. For more information, please see https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html.

Child Health

New Jersey's 2022 child health initiatives include:

- Cover All Kids: In 2021, NJ FamilyCare eliminated premium and waiting periods within our CHIP program. Since then, DMAHS has created and sustained a multi-stakeholder Cover All Kids Working Group through 2022 to collaborate on outreach to, and enrollment and retention of, every eligible child in New Jersey for NJ FamilyCare.
- CMMI's Integrated for Kids Model: Starting in January 2022, the NJ Integrated Care for Kids (NJ InCK) Model has been available to pediatric members residing in Ocean and Monmouth counties. Since 2020, DMAHS has supported the efforts of NJ's grantees (led by Hackensack Meridian Health), who have received funding since 2020 through a cooperative agreement from the federal Center for Medicare and Medicaid Innovation (CMMI) to implement the InCK Model in NJ. The NJ InCK Model has two components: One is a comprehensive screening that is available to all children in Medicaid and CHIP. The second is voluntary, family-centered, community based care coordination available only to the subset of children identified to have significant health complexity through screening. Both of these components are supported by a state payment model designed by the grantees and paid for by NJ FamilyCare. This initiative is expected to continue through December 2026. For more information, please see https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model .

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

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

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

New Jersey's goal for this IAP opportunity is to incentivize Managed Care Organizations (MCOs) to (1) better document the type, scope, frequency, amount, and duration of HCBS in member services plans, and (2) produce timelier, accurate, and valid claims reporting that corroborate the details for HCBS in the service plan. New Jersey aims to improve the delivery of services and member satisfaction/experience for community-dwelling individuals receiving HCBS.

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

VBP MLTSS Service Delivery

Phase 2 of the 2021 VBP MLTSS Service Delivery is based on the measurement period of January 1, 2020 to December 1, 2020, and evaluates the delivery of two service types to MLTSS members compared with authorized services, service type, quantity, and frequency as identified in the Plan of Care (POC), for HCBS members enrolled in the Medicaid Managed Care MLTSS program. The utilized services assessed in this methodology are: Home Delivered Meals, and Personal Care Assistance (PCA). The percent of services delivered for each service type evaluated will be based on the average percent of services delivered based on claims data.

In addition to evaluating the delivery of services in accordance with the POC, MCOs are evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS, PM #10: Plans of Care aligned with member's needs based on the results of the NJ Choice Assessment, and PM #11: Plans of Care developed using "Person-Centered Principles". Due to the COVID-19 pandemic, MCOs were mandated to suspend certain in-person Care Management activities, including the New Jersey Choice Assessment. Therefore, PM #10 was not evaluated during the 2021 MLTSS HCBS Care Management Audit. A sample of 120 cases for each of the services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. MCOs are required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation.

The EQRO has conducted an analysis of POCs in the CM records and compared the services listed to services delivered, as reflected by claims processed by the MCOs. The MCOs provided periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). Primary Source Verification with each MCO has been completed to ensure that their reported claims accurately reflect the claims in their transactional systems, and rate calculations are currently in progress. DMAHS review of rate calculations and MCO attestation was completed in early 2023.

MLTSS Home and Community Based Services (HCBS) Performance Payment

The Division's HCBS Performance Payment is designed to award top performance in plan of care development within the MLTSS Program. Introduced in the January 2022 Contract, beginning with SFY 2023, the Division will award the top two (2) Contractors using data collected by the External Quality Review Organization (EQRO) pertaining to the MLTSS HCBS Care Management Audit Performance Measures scores. The following

Performance Measures have been selected with reserved right to modify the measures chosen to calculate performance, as necessary: Performance Measure 8: Plans of Care established within required timeframe following MLTSS enrollment, Performance Measure 9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC redetermination, Performance Measure 9a: Plan of Care for MLTSS Members amended based on change of Member condition, Performance Measure 10: Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice assessment, Performance Measure 11: Plans of Care for MLTSS Members are developed using Person-Centered Principles.

MLTSS Nursing Facility Transition Incentive Program

The MLTSS Nursing Facility Transition Incentive program is designed to accelerate safe transitions where the Contractor has actively participated in successfully transitioning an enrollee from the Nursing Facility to the Community setting. Upon meeting eligibility criteria and submission documentation outlined in the Contract under Article 8.5.8 C., for each transition the MCOs will receive $20,000 up to the total ten (10) million dollars allocated for this program. Transition incentive payments will occur quarterly following the Division's review and approval. MCOs with serious deficiencies may not be considered for the incentive until the deficiency is resolved.

Expansion of NJ WorkAbility

In 2022, New Jersey began implementation of Senate Bill 3455 (P.L.2021, c.344), a new law to expand eligibility for NJ WorkAbility, a program that allows otherwise ineligible working people with disabilities to qualify for Medicaid. The legislation removes the previous age, income, and asset limitations on program eligibility. It also permits an eligible applicant to remain enrolled for up to a year after a job loss if not the fault of the member.

DMAHS has begun a phased implementation of this legislative mandate and will continue to move towards full implementation in 2023. Progress this year includes extensive stakeholder engagement as well as consultation with and technical assistance from CMS. Work has begun on the systems changes needed to support the lifting of income, asset, and age requirements. In Phase 1, New Jersey will implement new age and asset requirements and will expand coverage for those who recently lost a job. In Phase 2, New Jersey will remove income eligibility requirements.

New Jersey continues to implement this important program expansion in close consultation with stakeholders and our federal partners.

New Jersey DMAHS Quality Strategy

New Jersey maintains rigorous standards to ensure that approved health plans have networks and quality management programs necessary to serve all enrolled populations. New Jersey's Quality Strategy serves as a roadmap for ongoing improvements in care delivery and outcomes. Whether it be through new benefits and services, innovations, technology, or managed care accountability, New Jersey DMAHS is committed to serving Medicaid beneficiaries the best way possible.

The New Jersey DMAHS 2022 Quality Strategy focuses on achieving measurable improvement and reducing health disparities through three high priority goals. Based on the CMS Quality Strategy Aims framework, the State organized its goals by these aims: 1) better care; 2) smarter spending; and 3) healthier people, healthier communities.

CMS Aim 1: Better Care

Goal 1: Serve people the best way possible through benefits, service delivery, quality, and equity.

CMS Aim 2: Smarter Spending

Goal 2: Experiment with new ways to solve problems through innovation, technology, and troubleshooting.

CMS Aim 3: Healthier People, Healthier Communities

Goal 3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management.

In **Table 3**, the State has further identified 24 metrics to track progress towards the three goals listed above.

Table 3: NJ DMAHS Quality Strategy Goals

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
CMS Aim 1: Better Care				
Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.1: Improve maternal/child health outcomes	Prenatal and Postpartum Care	HEDIS PPC	NCQA 75th percentile
		Perinatal Risk Assessment (PRA) completion	N/A	Annual increase against baseline
		Well Child Visits	HEDIS W30, HEDIS WCV	NCQA 75th percentile
		Pediatric Dental Quality	CMS-416, NJ State Specific Measures	55% for NJ Specific
	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	Care Management Audits	EQRO	85%
		Autism service utilization	Measures in development	TBD
	1.3: Support independence for all	MLTSS Care Management Audits	EQRO	86%

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
	older adults and people with disabilities who need help with daily activities			
		HCBS Unstaffed Cases/ Workforce Challenges	MCO Accountability Reporting	0% of cases > 30 days
		Nursing Facility Transition/Diversion Reporting	MLTSS Performance Measures	> 246 transitions per month; < 18 admissions to NF per month
CMS Aim #2: Smarter Spending				
Goal #2: Experiment with new ways to solve problems through innovation, technology, and troubleshooting	2.1: Monitor fiscal accountability and manage risk	Minimum Loss Ratio (CMS Final Managed Care Rule)	DMAHS Finance	85% (non-MLTSS), 90% (MLTSS)
	2.2: Demonstrate new value-based models that drive outcomes	Perinatal Episode of Care Payment Metrics	Measures in development	
		MCO Primary Care Home Models	Measures in development	TBD
		COVID-19 Vaccine Incentives	MCO Reporting	90th percentile among State Medicaid programs
	2.3: Use new systems and technologies to improve program operations	Eligibility Redeterminations – *measures under development*	CMS Reporting	TBD
		MMIS provider module –	*Measures in development*	TBD
		Electronic Visit Verification (EVV) Compliance	DMAHS Managed Care Reporting	100%
CMS Aim 3: Healthier People, Healthier Communities				
Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.1: Address racial and ethnic disparities in quality of care and health outcomes	Breast Cancer Screening	HEDIS BCS	NCQA 75th percentile

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
		COVID-19 Vaccination Rates	MCO Reporting	90th percentile among State Medicaid programs
		Cervical Cancer Screening	HEDIS CCS	NCQA 75th percentile
	3.2: Hold operational partners accountable for ensuring a stable, accessible, and continuously improving program for our members and providers	Network Adequacy Reporting	DMAHS Accountability	under redevelopment
		MCO 1:1 performance accountability series	DMAHS Accountability	Case specific
		Operational Partner Scorecards	Measures in Development	TBD
	3.3: Ensure program integrity and compliance with State and Federal requirements	T-MSIS data quality	DMAHS IT	Gold status by Jan 2022 Blue status by Jan 2023
		Medicaid Provider Revalidation	DMAHS/Gainwell	Achieve and maintain full compliance

IPRO's Assessment of the New Jersey DMAHS Quality Strategy

The *2022 New Jersey DMAHS Quality Strategy* generally meets the requirements of *Title 42 CFR § 438.340 Managed Care State Quality Strategy* and acts as a framework for the MCOs to follow while aiming to achieve improvements in the **quality** of, **timeliness** of, and **access** to care. Goals and aims are clearly stated and supported by well-designed interventions, and methods for measuring and monitoring MCO progress toward improving health outcomes incorporate EQR activities. The Quality Strategy includes several activities focused on quality improvement that are designed to build an innovative, well-coordinated system of care that addresses both medical and non-medical drivers of health such as PIPs, financial incentives, VBP, health information technology, and other department-wide quality initiatives.

Recommendations to New Jersey DMAHS

Per *Title 42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations on how NJ DMAHS can target the goals and the objectives outlined in the State's Quality Strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to NJ MMC enrollees. As such, IPRO recommends the following to the NJ DMAHS:

- To effectively track progress towards meeting the State's goals for the Managed Medicaid program, DMAHS should consider updating the Quality Strategy to include performance metrics, baseline and remeasurement values, targets, and target year.
- DMAHS should consider incorporating summaries and results of state focus studies into the Quality Strategy.

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 2022-December 2022, this ATR includes IPRO's evaluation of the April 2022 and August 2022 PIP report submissions, final PIP submissions, and 1 Fall Prevention PIP submission. 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 EQR protocols. The MCOs will continue to submit project updates in April and August progress reports each year.

In June 2022, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed Stakeholder Engagement and Barrier Analysis. The training focused on PIP Development, Implementation, and current PIP issues.

Title 42 CFR § 438.356(a)(1) and *42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the DMAHS contracted with IPRO to validate the PIPs that were underway in 2022 **(Table 4).** Unless indicated as non-clinical, those PIPs are clinical. PIPs that are at the final report stage or proposal are noted.

Table 4: Core Medicaid and MLTSS PIP Topics

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

MCO	MCO PIP Title(s)[1]	State Topic
	PIP 4: Decreasing Gaps in Care in Managed Long-Term Services and Supports(MLTSS)	**Gaps in Care for MLTSS Population (Final Report)**
	PIP 5: Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS HCBS Population (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
Amerigroup New Jersey, Inc. (AGNJ)	**PIP 1:** MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors (Final Report)**
	PIP 2: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**
	PIP 3: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months (Core Medicaid)	**Early and Periodic Screening Diagnostic and Treatment (EPSDT)**
	PIP 4: Decreasing Gaps in Care in Managed Long-Term Services and Supports (MLTSS**)**	**Gaps in Care for MLTSS Population (Final Report)**
	PIP 5: Prevention of Falls in the Managed Long-Term Services and Supports (MLTSS) Population	**Falls Prevention for the MLTSS Population (Final Report)**
	PIP 6: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
Horizon NJ Health (HNJH)	**PIP 1:** MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors (Final Report)**
	PIP 2: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits – Core Medicaid Membership. (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**
	PIP 3: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population. (Core Medicaid)	**Early and Periodic Screening Diagnostic and Treatment (EPSDT)**
	PIP 4: Reducing Admissions, Readmissions and Gaps in Services for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting Population – (MLTSS)	**Gaps in Care for MLTSS Population (Final Report)**
	PIP 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Population (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
UnitedHealthcare Community Plan (UHCCP)	**PIP 1:** MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors (Final Report)**
	PIP 2: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**

MCO	MCO PIP Title(s)[1]	State Topic
	PIP 3: Improving Frequency of Well Visits in the First 30 months of Life and Compliance with Childhood Immunizations (Core Medicaid)	**Early and Periodic Screening Diagnostic and Treatment (EPSDT)**
	PIP 4: Improving Influenza and Pneumococcal Immunization Rates and Timely PCA Service in the Managed Long-Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population – (MLTSS)	**Gaps in Care for MLTSS Population (Final Report)**
	PIP 5: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**
WellCare Health Plans of New Jersey, Inc. (WCHP)	**PIP 1:** MCO Adolescent Risk Behaviors and Depression Collaborative (Core Medicaid)	**Adolescent Risk Behaviors (Final Report)**
	PIP 2: Medicaid Primary Care Physician Access and Availability (Non-Clinical – Core Medicaid)	**Access and Availability (Non-Clinical)**
	PIP 3: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations (Core Medicaid)	**Early and Periodic Screening Diagnostic and Treatment (EPSDT)**
	PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis (MLTSS)	**Gaps in Care for MLTSS Population (Final Report)**
	PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	**Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population**

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

Technical Methods of Data Collection and Analysis

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

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

Review Element 1: Topic and Rationale
Review Element 2: Aim
Review Element 3: Methodology:

- Study Population
- Study Indicator
- Sampling

Review Element 4: Barrier Analysis

Review Element 5: Robust Interventions:
- Improvement Strategies

Review Element 6: Results Table:
- Data Collection

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

Review Element 8: Sustainability

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

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. 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% for Core Medicaid	The MCO has demonstrated that it addressed the requirement.
Met	High	86% and above for MLTSS	The MCO has demonstrated that it addressed the requirement.
Partial Met	Moderate	60%-84%	The MCO has demonstrated that it addressed the requirement, however not in its entirety.
Not Met (Non-compliant)	Low	Below 60%	The MCO has not addressed the requirement.
N/A			Unable to evaluate performance at this time.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO reviewed the August 2022 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies (**Tables 6–11**). Current MCO specific PIP scoring reports along with IPRO findings can be found in **Appendix A: January 2022–December 2022 NJ MCO-Specific Review Findings**.

Table 6: PIP State Topic #1: Core Medicaid Adolescent Risk Behaviors and Depression

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	PM
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**2.5**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	PM	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM	M	M	PM
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**M**	**PM**
Element 5 Overall Score	**50**	**50**	**100**	**100**	**50**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**

New Jersey MCO PIP Scoring Report Adolescent Risk Behaviors and Depression (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7 b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	PM	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	PM	M	M	PM
Element 7 Overall Review Determination	**M**	**PM**	**M**	**M**	**PM**
Element 7 Overall Score	**100**	**50**	**100**	**100**	**50**
Element 7 Weighted Score	**20.0**	**10.0**	**20.0**	**20.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	PM	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	PM	M	M	M
Element 8 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 8 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 8 Weighted Score	**20.0**	**10.0**	**20.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N**	**Y**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**92.5**	**72.5**	**100.0**	**100.0**	**80.0**
Validation Rating Percent	**92.5%**	**72.5%**	**100%**	**100%**	**80.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**Moderate**	**High**	**High**	**Moderate**

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

Table 7: PIP State Topic #2: Core Medicaid Primary Care Providers Access and Availability

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1[1]	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**WCHP MY 2**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1[1]	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**WCHP MY 2**
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	M	M	PM
Element 5 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 5 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 5 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1[1]	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**WCHP MY 2**
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	PM	PM	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**PM**	**PM**	**M**	**M**
Element 7 Overall Score	**100**	**50**	**50**	**100**	**100**
Element 7 Weighted Score	**20.0**	**10.0**	**10.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N**	**N**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**72.5**	**70.0**	**70.0**	**80.0**	**72.5**
Validation Rating Percent	**90.6%**	**87.5%**	**87.5%**	**100%**	**90.6%**
Validation Status	**YES**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**High**	**High**	**High**	**High**

[1]ABHNJ revised their aim statement and performance indicators in 2021 resulting in a new PIP cycle.

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: Core Medicaid EPSDT Well Child Visits, Childhood Immunizations

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	PM	M	M	PM
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**PM**	**M**	**M**	**PM**
Element 2 Overall Score	**100**	**50**	**100**	**100**	**50**
Element 2 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**2.5**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	PM	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	PM	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	PM

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**PM**	**M**	**M**	**PM**
Element 3 Overall Score	**100**	**50**	**100**	**100**	**50**
Element 3 Weighted Score	**15.0**	**7.5**	**15.0**	**15.0**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	M	M	PM
Element 5 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 5 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 5 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	PM	M	M	PM
Element 6 Overall Review Determination	**M**	**PM**	**M**	**M**	**PM**
Element 6 Overall Score	**100**	**50**	**100**	**100**	**50**
Element 6 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**2.5**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**N**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**72.5**	**67.5**	**80.0**	**80.0**	**60.0**
Validation Rating Percent	**90.6%**	**84.4%**	**100%**	**100%**	**75.0%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**Moderate**	**High**	**High**	**Moderate**

Element 8 is not scored during measurement years 1 and 2.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 9: PIP State Topic # 4: MLTSS Gaps in Care

New Jersey MCO PIP Scoring Report MLTSS Gaps in Care (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M

New Jersey MCO PIP Scoring Report MLTSS Gaps in Care (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	PM	M	M	M
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**M**	**M**
Element 5 Overall Score	**50**	**50**	**100**	**100**	**100**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**

New Jersey MCO PIP Scoring Report MLTSS Gaps in Care (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**AGNJ Final**	**HNJH Final**	**UHCCP Final**	**WCHP Final**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	PM	M	M	M
Element 7 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**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	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	PM	PM	M	M
Element 8 Overall Review Determination	**M**	**PM**	**PM**	**M**	**M**
Element 8 Overall Score	**100**	**50**	**50**	**100**	**100**
Element 8 Weighted Score	**20.0**	**10.0**	**10.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	N	Y	N	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**92.5**	**72.5**	**90.0**	**100.0**	**100.0**
Validation Rating Percent	**92.5%**	**72.5%**	**90.0%**	**100%**	**100%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**Moderate**	**High**	**High**	**High**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 10: PIP State Topic # 5: MLTSS Fall Prevention

New Jersey MCO PIP Scoring Report Falls Prevention[1] (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ FINAL**	**HNJH**	**UHCCP**	**WCHP**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	M	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	M	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	M	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M	N/A	N/A	N/A
3b. Performance indicators are measured consistently over time	N/A	M	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Falls Prevention[1] (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ FINAL**	**HNJH**	**UHCCP**	**WCHP**
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**7.5**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	N/A	N/A	N/A
4f. Literature review	N/A	M	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**15.0**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	M	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	M	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**M**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**N/A**	**5.0**	**N/A**	**N/A**	**N/A**

New Jersey MCO PIP Scoring Report Falls Prevention[1] (Final Report Year) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ FINAL**	**HNJH**	**UHCCP**	**WCHP**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	PM	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	PM	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	M	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**PM**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**50**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**10.0**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	M	0	0	0
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	PM	0	0	0
Element 8 Overall Review Determination	**N/A**	**PM**	**0**	**0**	**0**
Element 8 Overall Score	**N/A**	**50**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**10.0**	**0.0**	**0**	**0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N/A**	**N**	**N/A**	**N/A**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**N/A**	**100**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**65.0**	**N/A**	**N/A**	**N/A**
Validation Rating Percent	**N/A**	**65.0%**	**N/A**	**N/A**	**N/A**
Validation Status	**N/A**	**Yes**	**N/A**	**N/A**	**N/A**
Validation Rating	**N/A**	**Moderate**	**N/A**	**N/A**	**N/A**

[1]AGNJ is the only MCO that has this PIP in progress. All other MCOs completed this project in a prior review cycle.
≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 11: PIP State Topic #6: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	PM
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**2.5**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	PM	PM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**PM**	**PM**
Element 4 Overall Score	**100**	**100**	**100**	**50**	**50**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**7.5**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	PM	PM	PM	M
Element 5 Overall Review Determination	**M**	**PM**	**PM**	**PM**	**M**
Element 5 Overall Score	**100**	**50**	**50**	**50**	**100**
Element 5 Weighted Score	**15.0**	**7.5**	**7.5**	**7.5**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population[1] (Year 1) (Clinical)	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**AGNJ MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WCHP MY 1**
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**80.0**	**72.5**	**72.5**	**65**	**70**
Validation Rating Percent	**100.0%**	**90.6%**	**90.6%**	**81.3%**	**87.5%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**High**	**High**	**Moderate**	**High**

[1]Scoring will occur in Measurement Year 1. In the current review period, all MCOs are at the proposal stage.

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 12 presents comparative performance for all MCOs across all PIP topics reviewed August 2022. PIP Topic #5 was completed in a prior review cycle for all MCOs except AGNJ.

Table 12: 2022 PIP Validation Results

MCO Compliance Level	PIP 1[1] Adolescent Risk and Behaviors Collaborative	PIP 2[1] Access and Availability	PIP 3[1] EPSDT – Well Child Visits & Childhood Immunizations	PIP 4[2] Gaps in Care for MLTSS Population	PIP 5[2] Falls Prevention for the MLTSS Population	PIP 6[2] Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
ABHNJ	92.5%	90.6%	90.6%	92.5%	N/A	100%
AGNJ	72.5%	87.5%	84.4%	72.5%	65.0%	90.6%
HNJH	100%	87.5%	100%	90.0%	N/A	90.6%
UHCCP	100%	100%	100%	100%	N/A	81.3%
WCHP	80.0%	90.6%	75.0%	100%	N/A	87.5%

[1] PIPs 1, 2, 3, are Core Medicaid PIPs.
[2] PIPs 4, 5, and 6 MLTSS PIPs.

Strengths

ABHNJ – Of the 5 PIPs scored, 3 performed above the 85% threshold for Core Medicaid indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS indicating high performance.

AGNJ – Of the 6 PIPs scored, 1 PIP performed above the 85% threshold for Core Medicaid indicating high performance; 1 PIP scored above the 86% threshold for MLTSS indicating high performance.

HNJH – Of the 5 PIPs scored, 3 performed above the 85% threshold for Core Medicaid indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS indicating high performance.

UHCCP – Of the 5 PIPs scored, 3 performed above the 85% threshold for Core Medicaid indicating high performance; 1 PIP scored above the 86% threshold for MLTSS indicating high performance.

WCHP – Of the 5 PIPs scored, 1 performed above the 85% threshold for Core Medicaid indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS indicating high performance.

Opportunities for Improvement

ABHNJ – Overall, ABHNJ was compliant in presentation of data and analysis of results, although should be mindful to review all calculations prior to submitting PIP reports.

AGNJ – Overall, AGNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing performance indicators that are clearly defined and measurable and that correspond with goals.

HNJN – Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include a full review of data, ensuring data corresponds with interventions and ensuring clarity for better comprehension.

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

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

Core Medicaid – Adolescent Risk Behaviors and Depression Collaborative PIP

All five MCOs participated in the Adolescent Risk Behaviors and Depression Collaborative. For this PIP, common performance indicators were used by all five MCOs. **Table 13** shows the comparative performance for each MCO.

Table 13: MCO PIP Results – Core Medicaid Adolescent Risk Behaviors and Depression Collaborative (2018–2022)

Indicators and Reporting Year	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Indicator 1: Tobacco Use					
2018 (Baseline)	63.63%	66.00%	99.05%	39.05%	89.38%
2019 Measurement Year 1 (MY 1)	63.00%	65.00%	99.05%	81.37%	89.52%
2020 Measurement Year 2 (MY 2)	63.00%	67.00%	98.10%	93.33%	98.06%
2021 Sustainability Year 3 (SY 3)	67.00%	100%	97.14%	82.86%	96.19%
Indicator 2: Alcohol Use					
2018 (Baseline)	55.55%	64.00%	88.57%	31.43%	89.38%
2019 Measurement Year 1 (MY 1)	63.00%	63.00%	98.10%	72.55%	82.86%
2020 Measurement Year 2 (MY 2)	70.00%	67.00%	98.10%	82.86%	97.09%
2021 Sustainability Year 3 (SY 3)	61.00%	100%	98.57%	82.86%	95.24%
Indicator 3: Drug Use					
2018 (Baseline)	54.54%	56.00%	87.62%	25.71%	89.38%
2019 Measurement Year 1 (MY 1)	61.00%	63.00%	98.10%	66.67%	82.86%
2020 Measurement Year 2 (MY 2)	73.00%	67.00%	98.10%	83.81%	95.15%
2021 Sustainability Year 3 (SY 3)	69.00%	100%	98.57%	100%	95.24%
Indicator 4: Sexual Behavior					
2018 (Baseline)	51.51%	64.00%	67.62%	25.71%	80.53%
2019 Measurement Year 1 (MY 1)	54.00%	63.00%	94.29%	69.61%	85.71%
2020 Measurement Year 2 (MY 2)	63.00%	54.00%	92.38%	82.86%	98.06%
2021 Sustainability Year 3 (SY 3)	61.00%	84.00%	95.17%	82.86%	96.19%
Indicator 5: Depression					
2018 (Baseline)	54.54%	75.00%	33.33%	45.71%	76.99%
2019 Measurement Year 1 (MY 1)	78.00%	95.00%	68.57%	82.35%	80.95%
2020 Measurement Year 2 (MY 2)	82.00%	100%	90.48%	91.43%	93.20%
2021 Sustainability Year 3 (SY 3)	80.00%	100%	87.14%	100%	80.00%

PIP Strengths

In 2022, the MCOs continued participation in a collaborative PIP titled "Adolescent Risk Behaviors and Depression Collaborative." The collaborative was instrumental in fleshing out barriers noted from each MCO and discussing constructive interventions to overcome the challenges during COVID-19. The MCOs were inventive and proactive in finding ways to facilitate capturing data while providing care to the memberships, ensuring members concerns continued to be addressed through telephonic and Telehealth avenues until face-to-face communications could resume. The final reports for the Adolescent Risk Behaviors and Depression Screening Collaborative were submitted, which completes this PIP.

Opportunities for Improvement

In Final Report Year 2022, three of the five MCOs overall experienced the following opportunities:

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

Interventions

All five MCOs engaged in a Core Medicaid collaborative PIP relating to adolescent risk behaviors and depression. **Table 14** provides a listing of interventions that each MCO implemented for this project.

Table 14: PIP Interventions Summary 2021–2022 for Adolescent Risk Behaviors and Depression

PIP	Interventions
ABHNJ - Adolescent Risk Behaviors and Depression	• **Eliza/Health Crowd** (Robo Outreach vendor) Adolescent Well Child outreach. Monitor successful outreach to intervention group members as evidence by outreach. • **Complete personalized person** to person outreach campaigns while in the provider setting to encourage adherence with AWC care for select provider, provider group and FQHC. • **Implement state approved AWC** incentive program and track adherence based on select provider, provider group and FQHC. • **All members will receive** an EPSDT mailer encouraging timely well child visits.
	• **Develop and train** the select provider, provider group, and FQHC on the intent of the performance Improvement project, outline pertinent data representative of adolescent screening rates, provide goals, and discuss the medical record review criteria and MCO support.
AGNJ - Adolescent Risk Behaviors and Depression	• **Educate provider quarterly** on the importance of one-on-one time with the adolescent during the members AWC utilizing the University of Michigan's Adolescent Health Initiative.
	• **Distribute examples** of high-risk behavior screening tools quarterly to the engaged providers during educational visits.
	• **Distribute scorecards** to providers via fax annually to review the results of the medical record review which assessed risk behavior screenings.
	• **Educate the providers** on the 5 risk behaviors and resources that are available when they screen positive for any of the screenings.
HNJH - Adolescent Risk Behaviors and Depression	• **This is a two-fold intervention** involving a member mailing and provider gap list. It will include a mailing to parents of children ages 12-17 that are due for a well visit. The mailing will address the importance of an annual visit, information relating to the four risk factors, the importance of routine screening, and emphasizing child-provider confidentiality to parent/guardians and adolescents assigned to the participating provider practices in Camden and Middlesex counties. Additionally, Providers will receive a gap list for those who were sent the letter and are due for a well-visit. • **This is a two-fold intervention** involving a member mailing and provider gap list. It will include a mailing to adolescents ages 18-21 that are due for a well visit. The mailing will address the importance of an annual visit, information relating to the four risk factors, and the importance of routine screening assigned to the participating provider practices in Camden and Middlesex counties. Additionally, Providers will receive a gap list for those who were sent the letter and are due for a well-visit.
	• **Initial collaborative meeting with providers** and staff at participating practices in Camden and Middlesex counties to discuss practice-related barriers along with an action plan to lessen or alleviate identified barriers. The providers will receive a handbook with information related to the risk behaviors during the initial touchpoint meeting. This

PIP	Interventions
	handbook will include: 1. Suggested screening tools 2. Acceptable billing codes 3. Clinical guidelines 4. Resources for positive screening outcomes Following the initial meeting, quarterly "touchpoint" meetings with practice providers and staff will take place and will focus on progress, newly encountered issues with revisions or additions to action plan. Providers will be audited (with audit tool) on random medical records to measure compliance based on the educational materials provided during the touchpoint visit. • **(Cooper and SP only):** Provide practice with list of acceptable billing codes to utilize when performing screening of adolescent risk behaviors and depression during adolescent well-care visits. (*Please note: this intervention does not apply to Princeton Medical Center (PMC) because they do not utilize Current Procedural Terminology (CPT) Codes). • **(Cooper only):** Provide practice with list of patients that had a CPT code for a depression screening so the staff can check for positive screenings and documentation of appropriate clinical responses for positive screenings.
	• **Provide participating groups** with standardized depression screening tools to utilize and include in screening process. Educate the providers on the American Psychological Association (APA) recommendations for depression and the use of screening tools. Work with groups on a one-on-one basis to implement the use of the standardized tools into the daily workflow. **Following the initial meeting**, quarterly "touchpoint" meetings with practice providers and staff will take place and will focus on progress, newly encountered issues with revisions or additions to action plan. Providers will be audited (with audit tool) on random medical records to measure compliance based on the educational materials provided during the touchpoint visit.
UHCCP - Adolescent Risk Behaviors and Depression	• **Monthly telephonic outreach and mail outs** to all adult members 18 and over or member parent/guardians of adolescents under 18 yrs. in the target member population who are scheduled for an AWC at each of the target practices to educate about the importance of adolescent health screenings and confidentiality during the screening process.
	• **Quarterly practice visits** by quality team to provide staff support and education, reinforce screening recommendations, review coding and reimbursements for adolescent screenings, conduct sample audit, and provide up to date referral resources. In addition, educational handouts that outline the importance of adolescent health screenings and confidentiality during the screening process will be given to the provider to distribute to members presenting to the office for AWC.
WCHP - Adolescent Risk Behaviors and Depression	• **All Providers (A, B, C) Tracking improvement** of medical record documentation: • Conduct interim medical record review and in-person provider visits in the 3rd and 4th quarters of each measurement year to review the results of the interim medical record review. • **Up to a maximum of 5 randomly** selected medical records will be audited in the 3rd and 4th quarter each measurement year to monitor provider documentation improvement regarding screenings and clinical response management.
	• **Targeted providers** will document in the medical records when youth-centric educational materials on risk behaviors and depression are distributed to adolescent members/families.
	• **Targeted practice sites** will be monitored for provider practice changes as a result of feedback based on medical record review at a quarterly visit by the QI Specialist. The QI Specialist will interview providers of the targeted practices and complete a Provider Site

PIP	Interventions
	Survey to identify barriers and interventions for improvement based on the results of the medical record review.

All five MCOs engaged in a Core Medicaid PIP relating to Access and Availability. **Table 15** provides a listing of interventions that each MCO implemented for this project.

Table 15: PIP Interventions Summary 2021–2022 for Access and Availability

PIP	Interventions
ABHNJ - Improving Access and Availability to Primary Care for the Medicaid Population	• **New Member Roster to Targeted PCPs** -Plan to give monthly roster to targeted providers identifying members on panel with new members flagged for outreach for a baseline appointment. **Appointments** to be monitored through quarterly claims data for an initial appointment and will be reported within the quarter that the claim is received.
	• **ER Notification to Targeted PCPs** – Plan to give monthly list of members who were seen in the ER for a LANE diagnosis, date of ER visit, diagnosis, and date of last PCP visit for provider follow-up. • **It will be the expectation** of the PCP to follow-up with members who visited the ER and had no PCP visits within the past 12 months to contact the member and schedule an annual visit to establish a relationship with the member and educate the member regarding appropriate use of the ER. • **Monitor claims** for PCP visit after ER notification given to provider.
	• **Practice Transformation Appt. Scheduling** – Plan to survey and work with targeted PCP offices to review and modify member triage and appointment scheduling procedures during business hours, as appropriate. Discussion to occur on a quarterly basis with Provider/Practice Manager.
	• **Practice Transformation After Hours Access** -Plan to survey and work with targeted PCP offices to review and modify after hours triage, as appropriate. Discussions to occur on quarterly basis with Provider/Practice Manager.
	• **Member Outreach (Not Seeing Assigned PCP)** – Plan to identify members assigned to PCP Practice without PCP claims in system on a quarterly basis (12- month look back) and conduct outreach to educated on the importance of a PCP and regular visits for preventive care. Members may request a new PCP assignment and will be referred to Member Services to complete the reassignment.
	• **Member Education** – Plan will develop flyer for member distribution to educate on the importance of PCP, appropriate use of ER, and availability of a 24- Hour Nurse Line (Informed Health Line). Monitor distribution and subsequent ER visits >14 days post mailing. • **Annual mailings** (1Q of each MY) will be conducted to all existing members assigned to targeted PCPs followed by mailings to new members assigned to targeted providers during the remaining quarters.
	• **Survey members assign to targeted practices via IVR** questionnaire to answer questions regarding Getting Needed Care. This information will be shared with PCP Practice for opportunities of improvement and monitored for performance through quarterly surveys. • **Annual surveys** (1Q of each MY) will be conducted to all existing members assigned to targeted PCPs followed by surveys to new members assigned to targeted providers the remaining quarters of the MY. This information will be shared with PCP Practice for opportunities of improvement and monitored for performance through quarterly surveys.
AGNJ - Increasing Primary Care Physician (PCP)	• **Education** via fax to all in-network provider groups regarding improving access and availability (including Telehealth options). (Quarterly) • **Monitoring the number of Telehealth visits** of the identified provider groups who received faxed Telehealth education.

PIP	Interventions
Access and Availability for the Amerigroup Members	• **Quarterly meeting** with identified provider groups for education and discussion of barriers, appointment availability and PCP visit data. • **Monitoring the number of PCP visits** (any type) of the identified provider groups who received education and barrier discussions.
	• **Text messaging** (3 times per year) to members attributed to the identified provider groups who have not had a PCP visit to stress the importance of preventative health visits to avoid inpatient admissions. • **Telephonic outreach** to members of the identified provider groups with failed text. • **Educational mailing** targeting members of the identified providers groups with failed texts and/or call restrictions (do not call carve outs) regarding the importance of PCP visits.
	• **Faxed list of attributed** members who have not had a PCP visit (well and sick) in the last year for the identified provider groups.
	• **Promotion and tracking** of provider incentive for well visits.
	• Promotion and tracking of member incentives for preventative services.
HNJH - Increasing PCP Access and Availability for members with low acuity, Non-emergent ED visits-Core Medicaid Membership	• **Educational materials** mailed to any member annually that experiences a LANE ED visit and has not had a PCP visit within the last 12 months. Education would be personalized to include the assigned PCP contact information, telemedicine alternatives, importance of annual visits, including preventive health screenings and immunizations, information on transportation and if additional assistance is needed Education would also include when and when not to utilize the ED. Educational materials and information will be sent to members on an annual basis. • **Visit reminders** sent to members biannually. Reminders are personalized to include the PCP contact information, contact information for transportation and if additional assistance is needed.
	• **Quarterly touchpoint meetings** with providers and staff in participating practice groups to focus on progress, newly encountered issues, or barriers of having members complete annual and follow-up visits (plan only). • **Bi-monthly list** sent to providers in participating practice groups of members with a LANE ED visit that have not been seen by the provider within 12 months.
	• **Education to providers** and staff in the participating practice groups on the Horizon HealthSphere application and enrollment with the application
UHCCP – Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members	• **Contact** Newark Community Health Centers, Rhomur Medical Services, and Forest Hills Family Health Associates adult Medicaid members who had an avoidable ED visit. Interview them about barriers to receiving care from a PCP on the day of the ED visit, educate them about appropriate ED usage, alternative sites of care and annual wellness visit.
	• **Assist in scheduling an appointment** with PCP for the adult Medicaid members assigned to Newark Community Health Centers, Rhomur Medical Centers and Forest Hills Family Health Associates who had an avoidable ED visit in the past quarter and are overdue for their annual physical.
	• **If the Newark Community Health Center**, Rhomur Medical Services and Forest Hills Family Health Associates adult Medicaid member indicates lack of transportation as a barrier to visiting the PCP office, educate them on medical transportation benefits offered by Medicaid.
	• **Work collaboratively** with identified practices to increase and monitor urgent appointment availability in order to reduce avoidable ED utilization.
	• **Refer adult Medicaid members** assigned to Newark Community Health Centers, Rhomur Medical Services and Forest Hills Family Health Associates who are high ED utilizers (4+ visits per calendar year) NJUHCCP Case Management department for evaluation for services.

PIP	Interventions
WCHP – Medical Primary Care Physician Access and Availability	• **Implementation of member education** materials for members assigned to PCPs included in the cohort. The proportion of the members who receive primary care educational materials VIA First Class mail. • **Telephonic outreach** to members (quarterly) who had two or more visits to the Emergency Room or the Urgent Care Center in the past six (6) months. • **The proportion of providers** who were telephonically outreached and educated about Medicaid Appointment Availability Standards. • **The proportion of providers** whose members indicated that they could not receive timely appointments and were educated about Medicaid Appointment Availability standards. • **The proportion of IPAs** that were outreached and educated on the Access and Availability standards. • **The proportion of the providers** who were given the handouts for display in their office.
	• **Implementation of provider outreach** to update their demographic profile via email or phone call.
	• **The proportion of Providers** who required ER/Urgent Care discussion based on their member utilization patterns.

All five MCOs engaged in a Core Medicaid PIP relating to EPSDT. **Table 16** provides a listing of interventions that each MCO implemented for this project.

Table 16: PIP Interventions Summary 2021–2022 for EPSDT: Increasing Early and Periodic Screening Diagnostic and Treatment Visits and Childhood Immunizations

PIP	Interventions
ABHNJ - Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations	• **Educate non-adherent members** with well child visits and/or immunizations about importance of visits and safety of vaccines IVR through HealthCrowd. The Plan will be specifically tracking the African American children for non-adherence due to vaccine hesitancy and lack of trust in the medical community.
	• **Identify members** without PCP claims in the system on a quarterly basis (12- month look back) and conduct member outreach for engagement and/or PCP reassignment.
	• **Provide roster to select providers** in targeted counties identifying new members on the panel with no well child visits and/or no CIS combo 9 vaccinations. Appointments to be monitored through quarterly claims data.
	• **Send letter to members** with a brochure who do not have claims for well child visits and/or no CIS combo 9 vaccinations on behalf of PCP for select provider offices that ABHNJ manages and mails which includes incentive information. The member letter will include the provider and Plan logo with the provider signature.
AGNJ - Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months	• **Parent/guardian education** on the importance of well visits and immunizations. Co-branded educational mailing addressing the importance of well visits to parents/guardians of children ages 0-30 months identified as missing a well visit from Pfizer/Amerigroup.
	• **Telephonic outreach** to parents/guardians of children ages 0-30 months identified as missing well visits.
	• **Parents/guardians** with children ages 0-30 months identified as missing well visits that required transportation assistance during telephonic outreach.
	• **Web-based member** education regarding vaccine safety. • **Co-branded educational** mailing addressing vaccine safety to parents/guardians of children ages 0-30 months identified as missing immunizations from Pfizer/Amerigroup.

PIP	Interventions
	• **Outreach to providers** identified as having 10% or more of eligible members with gaps in care for well visits and immunizations.
	• **Education for pediatricians** and family practice physicians on correct coding of well visits via fax.
	• **Implementation and promotion** of provider incentive for vaccine administration.
HNJH - Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population.	• **Parent/guardians** of new HNJH members less than 30 months of age will be sent targeted mailer highlighting recommended immunization schedule and the ability to obtain combination doses. Phone number for scheduling assistance will also be included. **Monthly member gap lists** to Primary care providers caring for children less than 30 months of age with list of members due for upcoming WCV and CIS to better assist in appointment scheduling prior to recommended WCVs and CIS.
	• **Parent/guardians** of HNJH members sent a reminder postcard that the member is behind schedule to complete six (6) well-child visits with their PCP by 15 months of age. Children 12 months of age or older with no well-child visits on record will be targeted for the reminder. **Parent/guardians of HNJH** members sent a reminder postcard that the member is behind schedule to complete two (2) well-child visits with their PCP by 30 months of age. Children 22 months of age or older with no well-child visits on record will be targeted for the reminder.
	• **Semi-annually deliver flier** to PCPs explaining ModivCare availability and how members may utilize their services to access the PCP. Information can be disseminated when attempting to schedule members with transportation challenges.
UHCCP - Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations.	• **Outreach to the parents/caregivers** of members assigned to Practice 1, 2 and 3 to remind them to schedule/keep their scheduled well baby appointments, educate on importance of preventive care.
	• **Provide case management** referral to parents/caregivers of members assigned to Practice 1, 2 and 3 who express that social determinants of health present a barrier to bringing their child for the well-baby visits.
	• **Monthly practice outreach/education** by UHCCP Clinical Practice Consultants (CPCs) to the staff at Practice 1, 2 and 3 regarding scheduling the well-baby appointment before the parent/caregiver leaves the office after a well-baby visit and reinforcing the importance of providing education to the member parent/ caregiver regarding adherence to the recommended immunization and well-baby visit schedule.
WCHP - Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations	• **Provide the following educational website** for parent/guardian education: Share and discuss the NEW Bright Futures Family Tip Sheet consistent with Bright Futures Guidelines, The Well-Child Visit: Why Go and What to Expect. **Provide the following** educational materials via mailings for parent/guardian education: Childhood Vaccine Schedule KRAMES; Well Child Check-up KRAMES; Preventative Guidelines Ages 2-18 KRAMES; **Educate parent/guardian** on the Novu Member Rewards Program. • **Referrals for parent/guardian** to FQHC to provide alternate night and weekend hours to maintain pediatric schedules for parent/guardian and offering appointment assistance and transportation assistance. • **Implementation of monthly** parent/guardian outreach to educate new mothers on the importance of Well-Child Visits and Immunizations. • **Quarterly Engagement** of 2 pilot providers to include: Provider Education of the PIP; Delivery of Provider Score Card to include WCV/Immunization Care Gaps; **Familiarize providers** with the Bright Futures Performing Preventive Services Handbook, which provides guidance on the most effective way to deliver the preventive services recommended in the Bright Futures Guidelines, 4th Edition. • **Provide prenatal education** regarding Bright Futures Vaccine Schedule and Well Child Visits.

All five MCOs engaged in an MLTSS PIP relating to Gaps in Care in the MLTSS population. **Table 17** provides a listing of interventions that each MCO implemented for this project.

Table 17: PIP Interventions Summary 2021–2022 for Gaps in Care in the MLTSS Population

PIP	Interventions
ABHNJ - Decreasing Gaps in Care in Managed Long-Term Services and Supports (MLTSS)	• **All members who** had a completed 90-day visit in the measurement period. The total number of completed visits with evidence of Red light, Yellow light, Green light member facing self-care management**.** • **All HCBS members who meet** the eligibility criteria will also have a condition specific assessment completed at each face-to-face visit (face to face visits includes 90-days visits and IP stays. • **All MLTSS members (HCBS and Assisted Living)** with diagnosis of CHF and/or COPD that have an IP event will have a F/U visit 10-Business days of Plan notification. • **All MLTSS members (HCBS and Assisted Living)** with diagnosis of CHF and/or COPD will also have a condition specific assessment completed at the face-to-face visit within 10 days following an Ip stay. • **All members who had a** face-to-face visit will have a disease specific person-centered care plan created. • **All eligible Members** will receive a 1- question health literacy assessment. • **All eligible members will** receive monthly contacts will include the completion of a specific signs and symptoms monitoring template based on their identified chronic illness. • **All monthly contacts** will include the completion of a specific signs and symptoms monitoring template based on their identified chronic illness.
	• **All members with an IP/ER visit** will receive a follow-up call within 72 hrs. of notification to the Plan of discharge (biweekly reporting). • **All members following an IP** stay will receive an in-home assessment within 10 days of notification to the Plan of discharge. (biweekly claims report). • **All members with an IP stay** will have a completed follow up visit with their PCP or specialist within 30 days of notification to the Plan of discharge.
	• **All ML TSS (HCBS and Assisted Living)** members will have documented confirmation that ACE and ARB therapy consistent with clinical guidelines post discharge for members with a diagnosis of CHF. • **All members will have documented confirmation** of Broncho dilators and corticosteroid treatment in place consistent with clinical guidelines post discharge for members with a diagnosis of COPD. • **All eligible members will receive** an annual influenza vaccination within the measurement period as evidenced by claims data. • **All eligible members will receive** an annual Pneumococcal vaccination within the measurement period as evidenced by claims data or PCP verification.
AGNJ - Decreasing Gaps in Care in Managed Long-Term Services and Supports (MLTSS)	• **On-site education** on flu vaccination (verbal and hard copy) during Case Management visit.
	• **On-site education** (verbal and hard copy) by Case Management staff on food resources available in the community.
	• **Identify members** on a quarterly basis based on NJ Choice assessment with a <18.5% BMI and outreach to identified members who do not have home delivered meals in place. Outreach and screen members for food insecurity. Refer members with a positive screening for care manager for further evaluation.
	• **Telephonic outreach** and education by dedicated Amerigroup associate prior to and during each flu season on the importance of well visits and Flu vaccinations.

PIP	Interventions
	• **Provide a list** of members with gaps in flu vaccinations to identified providers. As part of the process, Amerigroup will identify the top 2 providers in volume and non-compliance and discuss barriers and offer additional education with these providers.
	• **Provide a list of members** with gaps in flu vaccinations to all AMDC facilities. As part of the process, Amerigroup will identify the top 2 AMDCs in volume and non-compliance and discuss barriers and offer additional education with these facilities.
	• **Targeted outreach** to members to ensure member has chosen a provider/meal order.
HNJH - Reducing Admissions, Readmissions and Gaps in Services for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting Population – (MLTSS)	• **Educational materials** on CHF triggers and symptoms (green light/red light) will be reviewed with the member by MLTSS Care Manager during Face-to-Face visits (occurs per calendar year, not at each visit).
	• **MLTSS Care Manager** will conduct Outreach within 3 business days of an inpatient hospital discharge, including reminder/assistance in setting up post facility follow-up visit with member's PCP/Specialist. This will allow the Care Managers to address the members with the CHF condition sooner than the contractual timeframes. • **MLTSS Care Manager will conduct a 30-day pledge post hospital** which includes a face-to-face visit within 10 business days and telephonic outreach weekly. In addition, if the member has a home health aide the CM will attempt to engage the aide during the review of the CHF trigger/symptoms material(s). MLTSS clinical operations will monitor this on a monthly basis to confirm this takes place.
	• **HDM providers** with authorizations to service an MLTSS member with CHF who was discharged after an inpatient hospitalization will be contacted by the MLTSS care management team to inquire about member receipt of HDM/meals meeting dietary restrictions. Horizon will schedule calls with the HDM providers to identify ways to "lock" members into a low-sodium diet. If the member does not adhere to the dietary restrictions, CM will refer the member for a Nutrition Counseling (CPT 97802).
	• **PCA providers** with authorizations to service an MLTSS member with CHF will be contacted by the MLTSS care management team to inquire about member compliance noted during scheduled PCA visits. PCA providers will be educated to use the Horizon Alert forms when there is a potential gap in care. The Clinical Care Coordination staff will work with the providers to ensure delivery of service. PCA providers that are enrolled with Electronic Visit Verification EVV system will be monitored through the EVV system. This will be monitored on a quarterly basis by MLTSS Clinical Operations using internal claims reports. • **Any noted underutilization** of PCA services caused by the provider's inability will be referred to HNJH PC&S Department for provider outreach on members CHF monitoring and communication expectation. This will be monitored on a quarterly basis by MLTSS Clinical Operations using internal claims reports
	• **6. Any member with a history of CHF** with or without hospitalization can be referred to VRI. VRI (tele monitoring vendor utilized to assist HNJH CHF members) will provide MLTSS members with the ability to monitor their weight daily. If the member does not weight in, or if there are any variances with the member VRI will outreach to the member and CM. If a member is not currently involved with VRI and is admitted with a CHF diagnosis a Horizon RN will refer the member to VRI.
UHCCP - Improving Influenza and Pneumococcal Immunization Rates and timely PCA Service in the Managed Long-Term Services and	• **Education of members** that did not receive the **flu vaccination** regarding the importance of the flu vaccination during every face-to-face quarterly assessment. • **Education of members** that did not receive the pneumococcal vaccination regarding the importance of the pneumococcal vaccination during every face-to-face quarterly assessment.
	• **Coordination/facilitating removing** barriers to accessibility **for flu vaccination** during the face-to-face quarterly assessment by coordinating activities/arrangement (i.e., locating vaccine site, arranging transportation, and/or scheduling PCP office visit.

PIP	Interventions
Supports (MLTSS) Home and Community Based Services (HCBS) Population – (MLTSS)	• **Coordination/facilitating removing barriers** to accessibility for pneumococcal vaccination during the face-to-face quarterly assessment by coordinating activities/arrangement (i.e., locating vaccine site, arranging transportation, and/or scheduling PCP office visit.
	• **CM completes a follow up call** to MLTSS/HCBS member that had a Flu and/or Pneumococcal vaccination education during the face-to-face quarterly assessment to clarify and reinforce vaccination education; **CM completes follow up calls** to MLTSS/HCBS member that received Coordination of care during the face-to-face visit quarterly assessment to ensure Flu vaccination was received and CM coordinates services and activities to reschedule flu vaccination for members that did not get vaccination.
WCHP - Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis (MLTSS)	• **Implementation of member /caregiver/ PCA education;** Provide education and educational material (fact sheet) to members/ caregivers/PCA. Members presenting with pressure ulcers will be provided education and educational materials (fact sheet). • **The fact sheet includes** education on early detection signs and symptoms of sepsis and when to seek treatment, handwashing and handwashing steps, signs and symptoms wound infection, wound care/ sepsis prevention. • **Provide Sepsis Fact sheets**-with includes education for Sepsis, catheter care, UTIs and monthly calls.
	• **Physician notification** on early identification of sepsis; Inform PCPs that members are participating in a Sepsis PIP. • **Request that PCP complete** the PCP Sepsis Checklist and fax to WellCare MLTSS Dept., if any of these members visit office with s/s of sepsis. • **CM to follow up with physicians** if the members report s/s of sepsis during CM call or visit, or reports office visit for s/s of sepsis.
	• **Members without** MLTSS Services for Prevention of Sepsis (PCA, PPP, MDC, SNV). Implement MLTSS services for prevention, early identification, and coordination of timely treatment for community acquired sepsis to decrease inpatient sepsis admissions and inpatient sepsis mortality. • **Implement a Sepsis Prevention Protocol** which includes the following, Training the MLTSS providers regarding prevention of sepsis, signs/symptoms of early sepsis, and timely referrals for treatment; Implement Sepsis Checklist to track protocol implementation; Monitor effectiveness of Sepsis Prevention Protocol.

One MCO engaged in an MLTSS PIP relating to Falls Prevention. **Table 18** provides a listing of interventions that each MCO implemented for this project.

Table 18: PIP Interventions Summary 2021–2022 for Falls Prevention (Only 1 MCO)

PIP	Interventions
AGNJ - Prevention of Falls in the Managed Long-Term Services and Supports (MLTSS) Population	• **Amerigroup will educate** staff by providing facility-specific reports (including member detail) and fall prevention information on a semi-annual basis.
	• **Falls Risk Assessment** will be completed at every quarterly visit for home/community MLTSS members.
	• **Amerigroup will provide** on-site member education related to falls for nursing facility members on a semi-annual basis, at minimum and as needed.
	• **Amerigroup will provide** on-site member education related to falls for assisted living members on a semi-annual basis, at minimum and as needed.
	• **Amerigroup will educate** staff by providing facility-specific reports (including member detail) and fall prevention information on a semi-annual basis.

PIP	Interventions
	• **Amerigroup MLTSS field case managers** will demonstrate to members the use of the prescribed assistive device and confirm understanding by return demonstration and re-educate if needed**.** • **Amerigroup will complete** a referral for a PT/OT evaluation for members unable to demonstrate utilization of assistive device correctly upon return demonstration.

All five MCOs engaged in an MLTSS PIP relating to Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS HCBS Population. **Table 19** provides a listing of interventions that each MCO implemented for this project.

Table 19: PIP Interventions Summary 2021–2022 for Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

PIP	Interventions
ABHNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Increase documented interactions** between BH UM and MLTSS CM at least 3 times before member is discharged to ensure outpatient follow up needs are met. Documented interactions can be defined as: Communication via telephone, email, or in-person after admission, following concurrent review and at the time of discharge, Participation in a BH UM Rounds. • **BH UM will send** the discharge clinical information to the MLTSS CM within 48 hours following receipt from the hospital.
	• **Formalized information** gathering for Social Determinants of Health for all members will occur during the BH UM discussions to facilitate discharge planning. • **MLTSS HCBS members** with a behavioral health inpatient admit that have an identified SDoH issue or have been identified as being at high risk for nonadherence to discharge plan (based on the Immediate Outreach Trigger List) will receive outreach post discharge by their MLTSS CM within 48 business hours of the BH UM receiving discharge information from the facility to troubleshoot and resolve any barriers to attending behavioral health follow-up.
	• **BH UM will coordinate** the scheduling of a MH f/u visit pre-discharge. If appt is scheduled >7 days from discharge, BH UM will educate providers regarding BH appointment standards. If the scheduled appointment is not shared before discharge or the appointment is outside of the 7- and 30-day timeframe, the MLTSS Care Manager will work with the member to get an appointment scheduled within the appropriate timeframe. • **MLTSS Care Manager** will coordinate the scheduling of a BH f/u visit post-discharge if an appointment is not scheduled.
AGNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **1. Increase network of telehealth** mental health practitioners to improve appointment availability.
	• **2. Behavioral health team** to contact mental health provider to schedule/reschedule follow-up appointment for MLTSS HCBS members (within 7- and 30-days post discharge).
	• **3. Face-to-face visits** by a Behavioral Health Case Manager and/or MedZed for hard-to-reach MLTSS HCBS members discharged.
	• **4. Implementation and promotion** of provider incentive for FUH Compliance (7 Day-follow up and 30- Day follow-up.
	• **5. Monthly fax blast** of provider educational materials to facilities that have been identified as habitually late in providing discharge notifications to educate and encourage prompt discharge planning and notification.

PIP	Interventions
HNJH - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **1. The MLTSS Care Manager** will review generalized educational material with the member (regarding the stigma of mental illness, the importance of treatment and where to find help) emphasizing the importance of routine wellness visits to members with a HEDIS defined MH diagnosis.
	• **The CM will outreach** to engage and collaborate with any identified personal representatives, Assisted Living staff or house managers (boarding homes/group homes) as possible, regarding the importance of post facility ambulatory care within 10 business days of hospital discharge. • **The CM will outreach** the member and provide generalized education emphasizing the importance of routine wellness visits to members with a HEDIS defined MH diagnosis. • **The CM will escalate and refer** any member with a mental health related hospital readmission during the review period for the bi-weekly "Readmission Rounds Meeting" to be further reviewed by the MLTSS and BH Interdisciplinary Team meeting.
	• **The MLTSS Care Manager** will conduct outreach within 3 business days of an identified inpatient mental health related hospital discharge, this will allow the Care Managers to address the members needs with mental health related conditions sooner than the contractual timeframes. In addition, the MLTSS Care Manager will conduct a 30-day pledge post hospital, which includes a face-to-face visit within 10 business days and weekly telephonic outreach. • **The Outpatient mental health care providers** for MLTSS members with HEDIS defined mental health related dx and acute mental health related hospital discharge, will be outreached post hospital discharge. Outreach to include; offer for assistance with care coordination and confirmation of post facility follow-up appointment, share MLTSS CM contact information and request for outreach with member concerns or non-adherence with appointments. • **The MLTSS team will review** "claim discrepancy" twice monthly to help identify any previously unidentified hospitalizations covered by another payor i.e., Medicare or other commercial plans and outreach member for post facility outreach. **Inpatient mental health providers** will be educated on the importance of timely notification of inpatient admissions regardless of payor and reeducated on use of the Horizon Alert forms to help support and improve collaboration and the success of discharge planning.
	• **The MLTSS Care Management** and Behavioral Health teams will assist with coordinating follow up care appointment for members following mental health related hospital discharge. • **MLTSS members with HEDIS** defined mental health related diagnosis and an acute mental health related hospital discharge, will be provided with education on use and availability of telehealth appointments during the post facility contact.
UHCCP - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **1. Behavioral Health Advocate Care Manager** will make at least 3 attempts to contact the discharged member to establish care management services.
	• **Behavioral Health Advocate Care Manager** and MLTSS care manager collaborate with the hospital discharge planner to make sure that member's follow up appointment is scheduled prior to member's discharge, for the date within 30 days of discharge. • **Behavioral Health Advocate Care Manager** follows up that an appointment with a behavioral health provider is scheduled for the date within 30 days of discharge and member is aware of the scheduled appointment. **Member's Behavioral Health Advocate Care manager**, MLTSS Care Manager and Behavioral Health Medical Director hold an interdisciplinary team meeting to discuss the recently admitted member's plan of care within 1 week of member's inpatient admission notification.
	• **Behavioral Health Advocate Care Manager** provides a reminder phone call to the member 24-48 hours prior to the follow up appointment.

PIP	Interventions
	• **Behavioral Health Advocate Care Manager** follows up with member after the scheduled appointment to determine if the follow up appointment was completed. • **Behavioral Health Advocate Care Manager** follows up with member's provider after the scheduled appointment to determine if the follow up appointment was completed. • **If member did not complete** their appointment, Behavioral Health Advocate Care Manager reschedules the missed appointment.
	• **If the Behavioral Health Advocate Health Care Manager** determines that lack of transportation prevents the member from completing the follow up appointment, they advise/assist the member in utilizing telehealth to complete a follow up visit with a mental health practitioner. • **If the Behavioral Health Advocate Health Care Manager** determines that lack of transportation prevents the member from completing the follow up appointment, they assist the member in arranging medical transportation to complete a follow up visit with a mental health practitioner.
	• Behavioral Health Advocate Care Manager and MLTSS care manager follow up that member who declines to complete a follow up visit with a mental health provider within 30 days of discharge completes a follow up visit with a primary care provider within 30 days of discharge.
WCHP - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **WellCare to coordinate Provider** training on a quarterly basis on the identification of factors impacting member follow up and adherence to treatment protocols among members with a Behavioral Health diagnosis.
	• **Outreach members identified** with a recent Behavioral Health acute inpatient discharge and complete the Initial Contact for Behavioral Health Discharges Screening tool.
	• **Screening for SDOH factors** that present barriers for follow up treatment for members who have been recently discharged from an acute care setting with Behavioral Health diagnosis. • **Track referrals made** to community based MLTSS services for SDOH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Track referrals made** to community based resources for SDOH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services.
	• **Document member preference** of either in-person or telehealth follow up visits with primary care/specialist. Track utilization of telehealth services for 30-day follow-up visit among the members meeting criteria for the project.

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

Objectives

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. To meet these federal requirements, the New Jersey (NJ) Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has contracted with IPRO, an EQRO, to conduct the Review of Compliance with Medicaid and CHIP Managed Care Regulations. The Annual Assessment of MCO Operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of CFR 438.360(a)(1). The Annual Assessment of MCO Operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. All five MCOs participated in a 2022 compliance review; ABHNJ, AGNJ, HNJH, UHCCP and WCHP.

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

Effective 2019, the state moved to a new annual assessment audit cycle: 2 consecutive years of partial audits followed by 1 year of full audit. If the MCO scores less than 85% in the first partial audit, the MCO will have a full audit the following year. In 2022, full reviews were conducted for ABHNJ, AGNJ, HNJH, and UHCCP, and a partial review for WCHP. The reviews evaluated each health plan on 14 standards based on contractual requirements.

The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2022 is outlined in **Table 20.**

Table 20: 2022 Annual Assessment Type by MCO

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

Technical Methods of Data Collection and Analysis

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

The review consisted of pre-offsite review of documentation provided by the plan as evidence of compliance with the 14 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and audit activities. To assist in submission of appropriate documentation, IPRO developed the Annual Assessment of MCO Operations Review Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. The submission guide was provided

to the plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was July 1, 2021, to June 30, 2022.

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

Description of Data Obtained

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

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

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

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

The standard designations and assigned points used are shown in **Table 21.**

Table 21: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation

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

Conclusions and Comparative Findings

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these eleven (11) standards be evaluated. **Table 22** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards.

Table 22: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standards

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

Subpart D and QAPI Standards[1]	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[2]
Confidentiality	438.224	1 – Provider Training and Performance	PT9	1 – 2019-2020 and 2021-2022
Grievance and appeal systems	438.228	1 – Utilization Management 2- Quality Management	UM16a – UM16d, UM16f- UM16i, QM5	1 – 2021-2022 2 – 2021-2022
Subcontractual relationships and delegation	438.230	1 – Administration and Operations	AO5, AO8–AO11	1 – 2019-2020 and 2021-2022
Practice guidelines	438.236	1 – Quality Assessment and Performance Improvement (QAPI) 2 – Quality Management 3 – Programs for the Elderly and Disabled	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1 – 2019-2020 and 2021-2022 2 – 2019-2020 and 2021-2022 3 – 2019-2020 and 2021-2022
Health information systems	438.242	1 – Management Information Systems	IS1–IS17	1 – 2019-2020 and 2021-2022
Quality assessment and performance improvement (QAPI)	438.330	1 – Quality Assessment and Performance Improvement (QAPI)	Q1-Q3, Q5-Q9	1 – 2021-2022

[1] The categories QAPI and Care Management and Continuity of Care are reviewed annually. DMAHS requires specific elements to be reviewed annually.

[2] Within a 3-year cycle, four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a full compliance review in 2019-2020. One MCO (WCHP) had a partial compliance review in 2019-2020. All five MCOs had a partial compliance review in 2020-2021. Four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a partial compliance review in 2021-2022. One MCO (WCHP) had a full compliance review in 2021-2022. Four MCO's (ABHNJ, AGNJ, HNJH and UHCCP) had a full compliance review in 2022-2023. One MCO (WCHP) had a partial compliance review in 2022-2023.

Of the 239 elements reviewed during the 2022 Core Medicaid and MLTSS Annual Assessments, 81 elements crosswalk to the eleven (11) CMS QAPI Standards. **Table 23** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI Standards identified by CMS.

Table 23: Subpart D and QAPI Standards – Scores by MCO

Subpart D and QAPI Standards	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Availability of services	438.206	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	75%	67%	83%	67%	75%
Assurances of adequate capacity and services	438.207	A4	1	100%	100%	100%	100%	100%
Coordination and continuity of care	438.208	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	11	73%	64%	73%	64%	73%

Subpart D and QAPI Standards	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Coverage and authorization of services	438.210	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	7	100%	100%	100%	100%	100%
Provider selection	438.214	CR2, CR3, CM27	3	100%	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16a – UM16d, UM16f-UM16i, QM5	9	100%	100%	100%	100%	100%
Subcontractual relationships and delegation	438.230	AO5, AO8–AO11	5	100%	100%	100%	100%	100%
Practice guidelines	438.236	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%	100%
Health information systems	438.242	IS1–IS17	17	100%	100%	100%	100%	100%
Quality assessment and performance improvement program	438.330	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%	100%
Total Elements Reviewed			**81**					
Compliance Percentage				**93%**	**90%**	**94%**	**90%**	**93%**

As presented in **Table 23**, all five (5) MCOs participated in the 2022 Compliance Review. A total of 239 elements were reviewed by each MCO for a total of 1,195 elements reviewed overall. All five (5) New Jersey MCOs showed strong performance in the CMS Subpart D and QAPI Standards. All five MCOs received 100% compliance for 9 of the 11 standard domains. All five (5) MCOs were non-compliant in Availability of Services, and Coordination and Continuity of Care (**Table 23**).

Table 24 displays a comparison of the overall compliance score for each of the five MCOs from 2021 to 2022. For the review period July 1, 2021–June 30, 2022, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2022 compliance scores from the annual assessment ranged from 95% to 98% (**Table 24**). ABHNJ's compliance score increased from 91% to 97%; AGNJ's compliance score decreased from last year at 96% to 95%; HNJH's compliance score increased from 96% to 98%, UHCCP's compliance score increased from 94% to 96%; WCHP's compliance score remained at 97% (**Table 24**).

Table 24: Comparison of 2021 and 2022 Compliance Scores by MCO

MCO	2021 Compliance %	2022 Compliance %	% Point Change from 2021 to 2022
ABHNJ	91%	97%	+6
AGNJ	96%	95%	-1
HNJH	96%	98%	+2
UHCCP	94%	96%	+2
WCHP	97%	97%	0

In 2022, the average compliance score for five standards (Access, Quality Management, Programs for the Elderly and Disabled, Satisfaction, and Utilization Management) showed increases ranging from 1 to 10 percentage points (**Table 25**). In 2022, five standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Satisfaction, Utilization Management, and Management Information Systems) had an average score of 100%. Average compliance for three standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, and Management Information Systems) remained the same from 2021 to 2022 (**Table 25**). Five standards (Committee Structure, Provider Training and Performance, Enrollee Rights and Responsibilities, Credentialing and Recredentialing, and Administration and Operations) decreased 1 to 4 percentage points from 2021 to 2022. Access had the lowest average compliance score at 79% (**Table 25**).

Table 25: 2021 and 2022 Compliance Scores by Review Category

Review Category	MCO 2021	MCO Average 2022[2]	Percentage Point Change
Care Management and Continuity of Care – Core Medicaid[1]	85%	79%	-6
Care Management and Continuity of Care – MLTSS[1]	94%	100%	+6
Access	69%	79%	+10
Quality Assessment and Performance Improvement	100%	100%	0
Quality Management	87%	92%	+5
Efforts to Reduce Healthcare Disparities	100%	100%	0
Committee Structure	100%	96%	-4
Programs for the Elderly and Disabled	98%	99%	+1
Provider Training and Performance	100%	98%	-2
Satisfaction	96%	100%	+4
Enrollee Rights and Responsibilities	100%	97%	-3
Credentialing and Recredentialing	98%	94%	-4
Utilization Management	97%	100%	+3

Review Category	MCO 2021	MCO Average 2022[2]	Percentage Point Change
Administration and Operations	100%	99%	-1
Management Information Systems	100%	100%	0
Total[3]	**95%**	**97%**	**+2**

[1] In 2021 and 2022, the CM scores were not included in the overall compliance score.
[2] MCO average is the average of the compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP).
[3] Total is the average of compliance scores listed in **Table 25**.

Individual MCO 2022 Annual Assessment scores by element can be found in **Appendix A: January 2022–December 2022 NJ MCO-Specific Review Findings**.

Figure 2 depicts compliance scores since 2020. Compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) have remained at or above 90% for all 3 years.

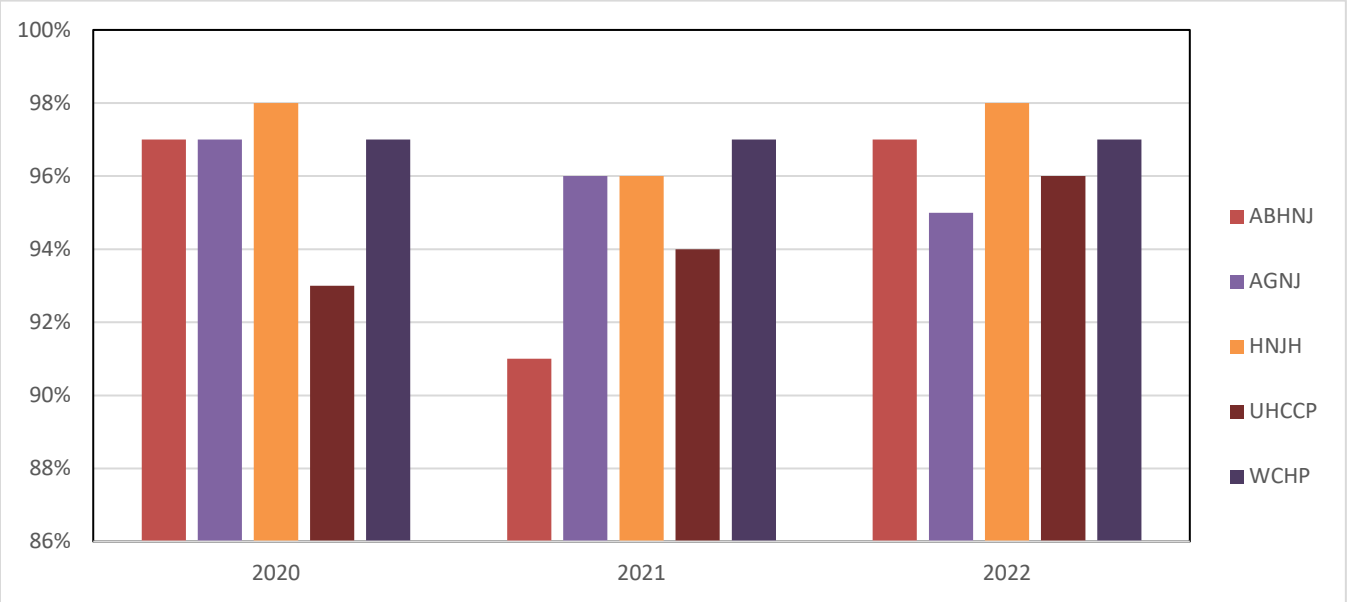


Figure 2: MCO Compliance Scores by Year (2020–2022). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, red); Amerigroup New Jersey, Inc. (AGNJ, purple); Horizon NJ Health (HNJH, orange), UnitedHealthcare Community Plan (UHCCP, brown); and WellCare Health Plans of New Jersey, Inc. (WCHP, grey) are shown for 2020–2022.

MCO Strengths

The MCO's strengths are the valuable resources, capabilities, and distinguishing characteristics that it has developed or acquired over time. A few of the individual MCO strengths identified as a result of the 2022 annual assessment of MCO operations are:

- The implementation and evaluation of a comprehensive Quality Assessment and Performance Improvement (QAPI) program that meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing quality improvement activities and demonstrates ongoing initiatives.
- All five MCOs continue to perform well with regard to Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Satisfaction, Utilization Management, and Management Information Systems.

Opportunities for Improvement

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

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

- Continue efforts in provider recruitment and improving access to hospitals, dental services, and primary care providers (PCPs) in all counties, including access to and coverage of out-of-network services as necessary;
- Continue to expand the MLTSS network to include at least two providers in every county;
- Continuing to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers;
- Implement planned interventions in a timely manner to have an effective impact on the outcome of the PIPs;
- Continue to strengthen analytic support and address deficiencies in implementation of the PIPs;
- Develop a comprehensive approach to ensure applicable performance measure documentation is submitted correctly and timely;
- Ensure timely resolution of member and provider grievances and appeals.

V. Validation of Performance Measures

Objectives

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

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

Technical Methods of Data Collection and Analysis

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS FAR prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable **(Table 26).** In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used, and medical record review procedures relevant to the calculation of the hybrid measures.

Description of Data Obtained

The five MCOs with performance data for MY 2021 (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) reported HEDIS MY 2021 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 2021 FARs to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 26).**

Table 26: MCO Compliance with Information System Standards – MY 2021

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

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

Information Systems Capabilities Assessments (ISCA)

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

The assessment covered the following areas:

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

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

All five MCOs undergo a systems review annually as part of their HEDIS audit by an NCQA Licensed Organization. IPRO reviews these results annually. In addition to the annual review of information systems (IS) that is conducted during the annual HEDIS review for each MCO in New Jersey, the Annual Assessment review conducted by IPRO for each organization includes review of 18 separate elements. Review of the IS elements includes live demonstration of systems.

IPRO's ISCA 2020 review findings and results by MCO are in **Table 27**.

Table 27: Information Systems Capabilities Assessment (ISCA) Results for 2020

MCO	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Standard[1]	Implications of Findings				
Completeness and accuracy of encounter data collected and submitted to the state.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Validation and/or calculation of performance measures.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Completeness and accuracy of tracking of grievances and appeals.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the information system to conduct MCO quality assessment and improvement initiatives.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to conduct MCO quality assessment and improvements initiatives.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications

MCO	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Standard[1]	Implications of Findings				
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to generate complete, accurate, and timely T-MSIS data.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the information system for review of provider network adequacy.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the MCO's information system for linking to other information sources for quality related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications

[1] Managed care organization (MCO) encompasses MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in *Title 42 CFR § 438.310(c)(2)*.

HEDIS MY 2021 Performance Measures

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

Conclusions and Comparative Findings

All of the five MCOs included their non-FIDE Dual Eligible members in the HEDIS submission, where the MCO was also the MCO for the Medicare product, which followed the NCQA HEDIS MY 2021 guidance.

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

ABHNJ, HNJH, UHCCP, and WCHP included FIDE SNP in their Medicaid reporting. ABHNJ had challenges in defining Dual, Disabled and Other populations based on the capitation codes. The population assignments were corrected to reflect the accurate eligibility designations in the member level file.

Overall, most measures remained constant from MY 2020 to MY 2021 (< 5 percentage point change). Significant increases and decreases (≥ 5 percentage point change) in performance from MY 2020 are noted below. Due to the impact of the Covid-19 pandemic, caution should be exercised in interpreting year-over-year performance for the MCOs.

Improvements in performance from MY 2020 to MY 2021:

- Comprehensive Diabetes Care (CDC)
  - HbA1c Testing improved by 5.69 percentage points.
  - HbA1c Poor Control (>9.0%) improved by 5.02 percentage points.
- Controlling High Blood Pressure (CBP) improved by 5.41 percentage points.
- Prenatal and Postpartum Care (PPC)
  - Postpartum Care improved by 6.93 percentage points.

- Appropriate Treatment for Upper Respiratory Infection (URI)
    - 65+ Years improved by 5.82 percentage points.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
    - BMI percentile – 12-17 Years improved by 6.86 percentage points.
    - Counseling for Nutrition – 3-11 Years improved by 5.39 percentage points.
    - Counseling for Nutrition – 12-17 Years improved by 8.53 percentage points.
    - Counseling for Nutrition – Total improved by 6.56 percentage points.
    - Counseling for Physical Activity – 12-17 Years improved by 10.54 percentage points.
    - Counseling for Physical Activity – Total improved by 7.03 percentage points.
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing
    - 1-11 Years improved by 5.38 percentage points.
    - 12-17 Years improved by 5.66 percentage points.
    - Total improved by 6.16 percentage points.
- Asthma Medication Ratio (AMR)
    - 19-50 Years increased by 5.42 percentage points.
- Annual Dental Visits (ADV)
    - 2-3 Years improved by 5.08 percentage points.
    - 4-6 Years improved by 6.10 percentage points.
    - 7-10 Years improved by 5.76 percentage points.
    - 11-14 Years improved by 5.19 percentage points.
    - 15-18 Years improved by 5.17 percentage points.

Decreases in performance from MY 2020 to MY 2021:

- Lead Screening in Children (LSC) decreased by 6.36 percentage points.
- Appropriate Testing for Pharyngitis (CWP)
    - 3-17 Years decreased by 6.42 percentage points.
    - 18-64 Years decreased by 7.19 percentage points.
    - 65+ Years decreased by 10.49 percentage points.
    - Total decreased by 9.62 percentage points.
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
    - Initiation Phase decreased by 5.29 percentage points.
    - Continuation and Maintenance Phase decreased by 5.17 percentage points.
- Follow-Up After Hospitalization for Mental Illness (FUH)
    - 18-64 years – 30-Day Follow-Up declined by 5.00 percentage points.

IPRO aggregated the MCO rates for the 33 measures included in the New Jersey Medicaid HEDIS grid and calculated weighted statewide averages to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e). HEDIS rates produced by the MCOs were also reported to the NCQA. Complete Audit Review Tables (ARTs) for each MCO are provided in **Appendix A: January 2022–December 2022 NJ MCO-Specific Review Findings.**

For this report, the MCOs' reported rates are compared to the NCQA HEDIS MY 2021 Quality Compass national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA HEDIS MY 2021 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles (**Table 28**).

Table 28: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2021 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2021 Quality Compass National Percentiles
Red	Below 10th Percentile
Orange	Between 10th and 25th Percentile
Yellow	Between 25th and 50th Percentile
Green	Between 50th and 75th Percentile
Blue	Above 75th Percentile
Purple	No percentiles released by NCQA

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

HEDIS data presented in this section include: Effectiveness of Care, Overuse/Appropriateness, Access/Availability of Care, Utilization and Risk Adjusted Utilization, and Electronic Clinical Data System measures. **Table 29** displays the HEDIS performance measures for MY 2021 for all MCOs and the New Jersey Medicaid Average. The Medicaid average is the weighted average of all MCO data.

Table 29: HEDIS MY 2021 Performance Measures

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Childhood Immunization (CIS)						
Combination 3	57.91%	54.50%	59.37%	52.80%	54.50%	57.01%
Combination 7	45.74%	38.44%	45.26%	41.85%	42.34%	43.42%
Combination 10	34.79%	28.95%	33.33%	30.90%	32.60%	32.22%
Lead Screening in Children (LSC)	66.67%	73.97%	62.57%	70.56%	70.80%	66.53%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months (6 or more visits)	52.40%	48.99%	52.17%	52.03%	44.41%	51.37%
Well-Child Visits for Age 15 Months – 30 Months (2 or more visits)	70.35%	75.14%	70.26%	70.25%	73.09%	71.10%
Child and Adolescent Well-Care Visits (WCV)						
3 – 11 years	63.84%	68.99%	67.10%	66.42%	70.60%	67.21%
12 – 17 years	55.76%	63.17%	62.49%	61.76%	63.88%	62.22%
18 – 21 years	31.77%	40.87%	38.71%	39.70%	39.01%	38.90%
Total Rate	55.89%	62.74%	60.85%	60.75%	62.70%	60.94%
Breast Cancer Screening (BCS)	43.33%	52.35%	54.32%	57.94%	57.88%	55.14%
Cervical Cancer Screening (CCS)	48.18%	61.48%	57.79%	62.53%	53.04%	58.36%
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	87.10%	85.16%	85.40%	87.35%	87.35%	86.05%
HbA1c Poor Control (>9.0%)[2]	35.77%	36.25%	33.09%	35.52%	36.01%	34.27%
HbA1c Control (<8.0%)	54.26%	54.99%	58.39%	58.39%	54.01%	57.60%
Eye Exam	50.12%	49.39%	54.50%	60.83%	56.69%	55.50%

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Blood Pressure Controlled <140/90 mm Hg	58.39%	52.31%	64.23%	62.04%	61.80%	62.22%
Controlling High Blood Pressure (CBP)	57.66%	50.12%	62.59%	61.80%	64.48%	61.22%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	64.29%	72.50%	85.37%	85.88%	70.45%	82.22%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
21-75 years (Male) – Received Statin Therapy	82.61%	79.33%	84.04%	84.09%	84.30%	83.61%
40-75 years (Female) – Received Statin Therapy	74.23%	76.03%	79.96%	77.39%	81.80%	78.80%
Total – Received Statin Therapy	79.93%	78.05%	82.29%	80.83%	83.10%	81.47%
21-75 years (Male) – Statin Adherence 80%	70.18%	71.08%	76.45%	77.57%	73.67%	75.95%
40-75 years (Female) – Statin Adherence 80%	76.39%	72.10%	76.82%	77.24%	73.89%	76.40%
Total – Statin Adherence 80%	72.02%	71.47%	76.61%	77.42%	73.77%	76.15%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	86.13%	86.81%	83.62%	83.45%	83.21%	84.39%
Postpartum Care	78.59%	81.25%	80.75%	80.05%	75.43%	80.37%
Immunizations For Adolescents (IMA)						
Meningococcal	83.45%	83.74%	87.31%	89.78%	81.27%	87.15%
Tdap/Td	86.86%	86.70%	90.40%	92.70%	86.62%	90.26%
HPV	30.66%	28.62%	34.01%	34.55%	31.39%	33.31%
Combination 1	82.24%	81.79%	86.28%	87.83%	78.59%	85.74%
Combination 2	28.71%	26.75%	32.32%	31.39%	29.20%	31.23%
Appropriate Testing for Pharyngitis (CWP)						
3-17 Years	84.46%	86.66%	53.75%	83.99%	75.15%	71.91%
18-64 Years	49.87%	55.91%	32.82%	49.36%	28.94%	40.00%
65+ Years	N/A	N/A	18.50%	14.35%	2.56%	13.52%
Total	69.77%	76.40%	43.70%	73.10%	54.29%	59.02%
Appropriate Treatment for Upper Respiratory Infection (URI)						
3 Months-17 Years	93.57%	93.46%	93.49%	92.83%	92.37%	93.30%
18-64 Years	66.15%	70.01%	64.02%	64.77%	61.51%	64.83%
65+ Years	81.40%	60.47%	57.00%	56.49%	69.60%	60.06%
Total	87.29%	89.23%	86.24%	85.34%	84.19%	86.43%
Chlamydia Screening (CHL)						
16-20 Years	59.96%	61.60%	55.32%	59.74%	65.32%	57.57%
21-24 Years	65.72%	61.43%	65.10%	67.79%	68.97%	65.21%

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Total	63.43%	61.51%	59.97%	62.97%	67.40%	61.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI percentile – 3-11 Years	85.61%	85.56%	87.32%	86.59%	88.39%	86.89%
BMI percentile – 12-17 Years	82.71%	84.33%	87.80%	86.06%	88.19%	86.85%
BMI percentile – Total	84.67%	85.16%	87.50%	86.37%	88.32%	86.87%
Counseling for Nutrition – 3-11 Years	81.65%	84.12%	84.88%	83.74%	85.77%	84.44%
Counseling for Nutrition – 12-17 Years	80.45%	76.12%	82.11%	82.42%	79.86%	81.31%
Counseling for Nutrition – Total	81.27%	81.51%	83.84%	83.21%	83.70%	83.29%
Counseling for Physical Activity – 3-11 Years	77.70%	80.87%	79.02%	78.86%	79.78%	79.23%
Counseling for Physical Activity – 12-17 Years	79.70%	76.12%	80.49%	81.21%	78.47%	80.01%
Counseling for Physical Activity – Total	78.35%	79.32%	79.57%	79.81%	79.32%	79.53%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	36.88%	30.63%	29.79%	32.08%	39.72%	30.84%
Continuation and Maintenance Phase	36.11%	31.11%	34.90%	39.60%	N/A	35.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing						
1-11 Years	33.33%	32.85%	19.45%	38.25%	15.63%	24.67%
12-17 Years	42.72%	39.69%	32.92%	45.58%	49.37%	36.85%
Total	40.00%	37.31%	28.54%	43.46%	39.64%	32.97%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	62.45%	60.78%	59.97%	65.51%	62.90%	61.41%
Effective Continuation Phase Treatment	45.69%	42.96%	46.76%	47.87%	45.02%	46.47%
Follow-Up After Hospitalization for Mental Illness (FUH)[5]						
6-17 years – 30-Day Follow-Up	45.54%	N/A	48.65%	N/A	41.25%	44.49%
6-17 years – 7-Day Follow-Up	24.11%	N/A	18.92%	N/A	22.50%	21.66%
18-64 years – 30-Day Follow-Up	39.59%	57.14%	47.51%	51.68%	37.13%	43.57%
18-64 years – 7-Day Follow-Up	23.49%	36.51%	28.35%	32.56%	23.10%	26.52%
65+ years – 30-Day	N/A	N/A	45.10%	44.44%	N/A	43.42%

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Follow-Up						
65+ years – 7-Day Follow-Up	N/A	N/A	11.76%	29.17%	N/A	23.03%
Total – 30-Day Follow-Up	40.23%	54.17%	47.33%	50.31%	38.20%	43.66%
Total – 7-Day Follow-Up	23.57%	34.72%	25.80%	31.03%	23.37%	25.78%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[5]						
6-17 years – 30-Day Follow-Up	61.54%	64.12%	74.53%	69.42%	67.19%	71.79%
6-17 years – 7-Day Follow-Up	57.40%	54.12%	65.66%	61.27%	52.34%	62.95%
18-64 years – 30-Day Follow-Up	56.95%	57.79%	63.36%	60.17%	69.73%	61.92%
18-64 years – 7-Day Follow-Up	50.77%	50.61%	55.44%	52.33%	60.88%	54.18%
65+ years – 30-Day Follow-Up	N/A	N/A	67.92%	46.07%	N/A	54.88%
65+ years – 7-Day Follow-Up	N/A	N/A	58.49%	34.83%	N/A	45.12%
Total – 30-Day Follow-Up	58.01%	60.13%	67.69%	63.04%	68.43%	65.44%
Total – 7-Day Follow-Up	52.32%	51.97%	59.39%	54.98%	57.83%	57.28%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)[5]						
13-17 years – 30-Day Follow-Up	N/A	N/A	13.40%	15.52%	N/A	13.90%
13-17 years – 7-Day Follow-Up	N/A	N/A	9.28%	13.79%	N/A	10.85%
18 and older – 30-Day Follow-Up	17.86%	18.39%	25.33%	18.55%	17.63%	22.70%
18 and older – 7-Day Follow-Up	12.47%	12.85%	17.37%	12.88%	12.23%	15.64%
Total – 30-Day Follow-Up	17.76%	18.38%	25.09%	18.48%	17.48%	22.53%
Total – 7-Day Follow-Up	12.40%	12.93%	17.20%	12.90%	12.24%	15.54%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	86.38%	85.46%	79.34%	85.95%	80.20%	81.80%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	52.92%	62.17%	67.09%	69.54%	71.57%	67.14%

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	64.60%	73.84%	79.53%	80.54%	69.75%	77.47%
45-64 Years	74.84%	81.18%	87.34%	87.95%	83.91%	85.87%
65+ Years	76.28%	82.18%	92.23%	93.09%	92.55%	91.49%
Total	68.27%	76.34%	82.72%	85.02%	77.94%	81.25%
Asthma Medication Ratio (AMR)						
5-11 Years	65.12%	73.52%	78.97%	66.01%	70.91%	74.95%
12-18 Years	63.33%	65.87%	71.46%	62.87%	62.26%	68.66%
19-50 Years	69.95%	57.87%	65.78%	58.53%	49.43%	63.06%
51-64 Years	68.70%	54.90%	65.02%	59.80%	51.98%	62.65%
Total	68.21%	61.48%	68.41%	60.74%	52.95%	65.61%
Annual Dental Visit (ADV)						
2-3 Years	34.13%	33.34%	41.74%	45.59%	38.14%	40.58%
4-6 Years	52.37%	58.36%	60.20%	66.87%	57.44%	60.84%
7-10 Years	54.72%	62.67%	64.36%	70.98%	60.40%	65.04%
11-14 Years	51.54%	59.56%	62.03%	68.07%	58.67%	62.57%
15-18 Years	42.59%	50.33%	55.87%	60.45%	49.77%	55.56%
19-20 Years	30.99%	34.87%	42.13%	45.49%	31.70%	41.00%
Total	46.35%	52.93%	57.20%	62.92%	51.99%	57.22%
Use of Opioids at High Dosage (HDO)[2]	9.68%	10.87%	12.24%	10.20%	6.48%	11.37%
Use of Opioids from Multiple Providers (UOP)[2]						
Multiple Prescribers	18.76%	17.32%	18.36%	12.70%	9.47%	16.67%
Multiple Pharmacies	3.11%	1.26%	1.80%	1.25%	1.03%	1.65%
Multiple Prescribers and Multiple Pharmacies	1.84%	0.78%	0.91%	0.61%	0.36%	0.84%
Risk of Continued Opioid Use (COU)[2]						
18-64 years – >=15 Days covered	5.16%	2.94%	5.73%	6.37%	10.24%	5.72%
18-64 years – >=31 Days covered	2.95%	2.02%	3.60%	3.93%	4.83%	3.52%
65+ years – >=15 Days covered	7.94%	13.83%	13.07%	16.23%	17.52%	15.03%
65+ years – >=31 Days covered	6.35%	9.57%	6.40%	9.63%	7.01%	8.13%
Total – >=15 Days covered	5.21%	3.09%	5.92%	7.49%	11.12%	6.15%
Total – >=31 Days covered	3.02%	2.12%	3.68%	4.58%	5.09%	3.74%
Plan All-Cause Readmissions (PCR)[3]						
Index Stays per Year – 18-44	11.78%	10.38%	10.72%	9.14%	9.79%	10.44%
Index Stays per Year – 45-54	15.46%	12.80%	10.78%	9.59%	13.19%	11.11%
Index Stays per Year – 55-64	10.65%	11.56%	12.54%	10.97%	12.66%	12.09%
Index Stays per Year – Total	12.31%	11.26%	11.23%	9.81%	11.50%	11.06%

HEDIS MY 2021 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Observed-to-Expected Ratio	1.26	1.15	1.16	0.99	1.17	
Ambulatory Care – Outpatient Visits per Thousand Member Months (AMB)[4]						
Total – Total Member Months	304.28	363.77	395.89	445.87	484.43	400.85
Dual Eligibles – Total Member Months	NQ	484.36	1066.01	898.05	1,136.15	968.30
Disabled – Total Member Months	NQ	333.71	636.36	591.31	807.73	631.16
Other Low Income – Total Member Months	NQ	363.17	364.16	382.38	391.01	368.89
Ambulatory Care – Emergency Room Visits per Thousand Member Months (AMB)[4]						
Total – Total Member Months	40.87	35.20	49.16	41.33	43.30	45.03
Dual Eligibles – Total Member Months	NQ	60.62	67.21	58.35	53.31	60.77
Disabled – Total Member Months	NQ	37.66	78.45	71.08	65.15	74.81
Other Low Income – Total Member Months	NQ	35.01	46.71	36.86	40.20	42.72
ELECTRONIC CLINICAL DATA SYSTEMS						
Prenatal Immunization Status (PRS-E)						
Influenza	17.82%	12.78%	18.46%	20.16%	18.01%	17.56%
Tdap	37.06%	28.35%	35.97%	31.50%	31.71%	33.70%
Combination	13.09%	8.20%	12.50%	12.61%	9.83%	11.62%

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

[2]Higher rates for HbA1c Poor Control, COU, HDO, and UOP indicate poorer performance.

[3]PCR's rate is based on observed count of 30-day readmission/count of index stays, and the ratio is observed-to-expected ratio with risk adjustment. For PCR, a lower ratio is indicative of better performance.

[4] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance. ABHNJ received a NQ (Not Required) for Duals, Disabled, Other Low Income from their HEDIS auditor, however, these breakouts were required by DMAHS.

[5] FUH and FUM are mental health measures. FUA is a chemical dependency measure. FUH requires full mental health benefits (inpatient and outpatient). FUM and FUA only require partial mental health or chemical dependency benefits. In the NJ Medicaid population, only DDD, MLTSS and FIDE SNP members have full behavioral benefits from the MCO. Two plans (AGNJ and UHCCP) restricted these three measures to the DDD, MLTSS and FIDE SNP populations from the MCO. ABHNJ and WCHP included the full population in the FUH, FUM and FUA measures. HNJH included the full population in the FUM and the FUA measures. HNJH restricted its population in the FUH measure, based upon the removal of any members without a full mental health benefit, and HNJH noted that the exclusion of fee-for-service membership from the eligible population would also have been a contributing factor.

Designation N/A: for non-ambulatory measures, indicates that the MCO had a denominator less than 30. For ambulatory measures, indicates that the MCO had 0 member months in the denominator.

Designation NR: indicates that the MCO did not report for the measure.

Designation NQ: indicates not required.

Designation CNC: averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.

MY 2021 New Jersey State-Specific Performance Measures

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

The required measures are:

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

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

The changes from MY 2020 to MY 2021 are:

1. Preventive Dental Visit: Age group 1 year was added to Total Medicaid, Medicaid/Medicare Dual-Eligibles, Medicaid-Disabled, and Medicaid-Other Low Income populations.

Conclusions and Comparative Findings

1. For MY 2021 ABHNJ, AGNJ, HNJH, UHCCP, and WCHP included FIDE SNP dual members in the Preventive Dental Visit measure.
2. ABHNJ included commercial members in the member level files submitted for the Preventive Dental Visit measure. The commercial members were removed from the member level files and rates were recalculated without the commercial members. ABHNJ also had challenges in defining Dual, Disabled and Other populations based on the capitation codes. The population assignments were corrected to reflect the accurate eligibility designations in the member level file.
3. Overall performance for all five MCOs increased for the Preventive Dental measure.
4. Overall performance for all five MCOs declined for Multiple Lead Testing in Children- Screening between 9 months and 18 months measure.

Table 30 shows state-specific performance measures for MY 2021 for all MCOs and the New Jersey Medicaid average.

Table 30: MY 2021 NJ State-Specific Performance Measures

MY 2021 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Preventive Dental Visit[2]						
Total – 1 Year	12.38%	9.12%	14.09%	16.92%	17.97%	13.63%
Total – 2-3 Years	33.41%	32.59%	38.86%	44.95%	37.50%	38.67%
Total – 4-6 Years	50.68%	56.62%	57.27%	65.30%	55.53%	58.46%
Total – 7-10 Years	52.25%	60.17%	61.11%	68.82%	58.09%	62.19%
Total – 11-14 Years	48.35%	55.96%	57.30%	64.84%	55.58%	58.42%
Total – 15-18 Years	38.10%	44.96%	48.66%	55.49%	45.51%	49.26%
Total – 19-21 Years	25.48%	29.59%	33.80%	39.73%	25.58%	33.65%
Total – 22-34 Years	22.36%	25.04%	30.85%	34.61%	22.58%	29.55%
Total – 35-64 Years	24.13%	26.78%	29.89%	33.46%	25.67%	29.64%
Total – 65+ Years	26.45%	23.66%	21.17%	25.28%	25.35%	24.63%
Total – Total	30.40%	36.18%	41.10%	44.97%	32.21%	40.19%
Dual Eligibles – 1 Year	N/A	N/A	N/A	N/A	N/A	N/A

MY 2021 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Dual Eligibles – 2-3 Years	N/A	N/A	N/A	N/A	N/A	N/A
Dual Eligibles – 4-6 Years	N/A	N/A	N/A	N/A	N/A	N/A
Dual Eligibles – 7-10 Years	N/A	N/A	N/A	N/A	N/A	N/A
Dual Eligibles – 11-14 Years	N/A	N/A	N/A	N/A	N/A	N/A
Dual Eligibles – 15-18 Years	N/A	N/A	N/A	N/A	N/A	N/A
Dual Eligibles – 19-21 Years	N/A	24.39%	45.45%	36.14%	N/A	32.04%
Dual Eligibles – 22-34 Years	19.71%	23.14%	30.04%	35.85%	27.54%	29.89%
Dual Eligibles – 35-64 Years	27.07%	27.41%	30.25%	35.00%	28.71%	31.49%
Dual Eligibles – 65+ Years	28.05%	24.41%	33.58%	25.90%	26.48%	25.46%
Dual Eligibles – Total	27.34%	25.22%	31.32%	29.03%	26.86%	27.41%
Disabled – 2-3 Years	N/A	7.69%	9.13%	25.00%	N/A	9.71%
Disabled – 1 Year	28.33%	31.33%	38.39%	45.20%	34.62%	38.43%
Disabled – 4-6 Years	34.17%	45.08%	51.47%	57.33%	42.74%	51.28%
Disabled – 7-10 Years	40.12%	44.13%	54.57%	53.98%	46.50%	52.86%
Disabled – 11-14 Years	36.05%	45.50%	50.12%	53.47%	36.87%	49.86%
Disabled – 15-18 Years	33.33%	33.93%	42.80%	45.44%	31.49%	42.11%
Disabled – 19-21 Years	19.69%	24.86%	31.19%	35.48%	21.92%	30.78%
Disabled – 22-34 Years	23.00%	24.71%	31.02%	30.99%	24.27%	29.60%
Disabled – 35-64 Years	25.31%	23.36%	25.42%	26.34%	25.68%	25.29%
Disabled – 65+ Years	18.98%	16.87%	18.38%	18.00%	17.81%	17.90%
Disabled – Total	24.69%	26.46%	31.79%	33.07%	24.45%	30.76%
Other Low Income – 1 Year	12.46%	9.13%	14.14%	16.86%	18.12%	13.67%
Other Low Income – 2-3 Years	33.47%	32.60%	38.86%	44.94%	37.55%	38.68%
Other Low Income – 4-6 Years	51.06%	56.88%	57.46%	65.58%	55.88%	58.68%
Other Low Income – 7-10 Years	52.61%	60.62%	61.39%	69.52%	58.45%	62.57%
Other Low Income – 11-14 Years	48.67%	56.33%	57.64%	65.41%	56.25%	58.81%
Other Low Income – 15-18 Years	38.21%	45.39%	48.94%	56.04%	46.07%	49.60%
Other Low Income – 19-21 Years	25.73%	29.87%	33.93%	40.06%	25.79%	33.81%
Other Low Income – 22-34 Years	22.41%	25.13%	30.84%	34.90%	22.32%	29.54%
Other Low Income – 35-64 Years	23.84%	27.07%	30.46%	34.18%	25.21%	30.05%
Other Low Income – 65+ Years	20.47%	20.29%	21.35%	24.54%	18.18%	30.17%
Other Low Income – Total	30.98%	38.26%	41.85%	49.18%	34.61%	41.85%
Multiple Lead Testing in Children through 26 Months of Age (MLT)						
Screening between 9 Months and 18 Months	57.09%	64.62%	47.97%	57.53%	62.61%	53.64%
Screening at 18 Months through 26 Months	41.41%	50.36%	41.17%	44.26%	47.04%	43.48%
Screening between 9 Months and 18 Months AND Screening at 18 Months through 26 Months	27.91%	38.07%	23.36%	29.25%	35.52%	27.58%

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

[2] MY 2021 is the first year NJ is reporting the 1 Year age cohort in the Preventive Dental Visit (NJD) measure.

Designation N/A: the plan had less than 30 members in the denominator.

Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

MY 2021 New Jersey Core Set Performance Measures

DMAHS requested the MCOs to submit seven (7) Core Set Measures in MY 2021:
Four Child Core Set Measures are reported:

1. Developmental Screening (DEV-CH)
2. Contraceptive Care Postpartum Women ages 15-20 (CCP-CH)
3. Contraceptive Care All Women ages 15-20 (CCW-CH)
4. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)

Three Adult Core Set Measures are reported:

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

The changes from MY 2020 to MY 2021 are:

1. Screening for Depression and Follow-Up Plan: Ages 12 to 17 was added.

Conclusions and Comparative Findings

No significant year over year changes were noted for the three (3) Adult Core Set measures or the four (4) Child Core Set measures reported.

Table 31 shows the New Jersey Core Set Measures for MY 2021 for all MCOs and the New Jersey Medicaid average.

Table 31: MY 2021 NJ Core Set Measures

MY 2021 NJ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Developmental Screening in The First Three Years of Life						
1 year old	31.71%	27.16%	40.54%	31.55%	34.11%	36.18%
2 year old	49.93%	56.99%	50.21%	43.92%	39.52%	49.56%
3 year-old	44.54%	51.26%	44.19%	39.62%	37.41%	44.07%
Total – 1-3 year	43.60%	47.07%	45.47%	39.79%	37.64%	44.24%
Diabetes Short-Term Complications Admission (PQI01) – Admissions per 100,000 Member Months[2]						
18-64	7.07	8.20	18.20	13.32	12.51	14.97
65 Years and Older	5.85	14.46	14.29	10.59	10.21	12.08
Total	7.02	8.75	18.04	12.93	12.20	14.76
Contraceptive Care – Postpartum Women						
Postpartum Women Ages 15-20 – Most or moderately effective contraception – 3 days	1.56%	0.00%	3.77%	3.18%	2.63%	3.10%
Postpartum Women Ages 15-20 – Most or moderately effective contraception – 60 days	25.00%	30.82%	33.45%	26.36%	15.79%	31.10%
Postpartum Women Ages 15-20 – LARC – 3 days	0.00%	0.00%	0.11%	0.00%	0.00%	0.07%

MY 2021 NJ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	NJ Medicaid Average[1]
Postpartum Women Ages 15-20 – LARC – 60 days	0.00%	5.66%	4.45%	4.09%	2.63%	4.27%
Postpartum Women Ages 21-44 – Most or moderately effective contraception – 3 days	5.58%	5.28%	9.64%	8.67%	6.41%	8.18%
Postpartum Women Ages 21-44 – Most or moderately effective contraception – 60 days	31.68%	34.75%	32.72%	35.43%	29.10%	33.31%
Postpartum Women Ages 21-44 – LARC – 3 days	0.13%	0.07%	0.11%	0.13%	0.12%	0.11%
Postpartum Women Ages 21-44 – LARC – 60 days	4.96%	4.58%	4.48%	5.08%	3.70%	4.60%
Contraceptive Care – All Women						
All Women Ages 15-20 – Provision of most or moderately effective contraception	15.92%	13.96%	16.74%	13.46%	12.28%	15.54%
All Women Ages 15-20 – Provision of LARC	0.84%	0.79%	1.00%	0.73%	0.74%	0.90%
All Women Ages 21-44 – Provision of most or moderately effective contraception	22.45%	25.28%	24.31%	23.19%	20.88%	23.98%
All Women Ages 21-44 – Provision of LARC	2.41%	2.90%	2.59%	2.48%	2.17%	2.58%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)[3]						
12-17 Years	1.24%	2.35%	1.86%	1.68%	0.89%	1.82%

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

[2] Higher rates for PQI-O1 indicate poorer performance.

[3] MY 2021 is the first year NJ is reporting the Screening for Depression and Follow-Up Plan (CDF-CH) measure.

Designation N/A: the plan had less than 30 members in the denominator.

Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

WYE 2022 MLTSS Performance Measures

Specifications were updated in 2021 for the July 2021 through June 2022 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member level files, and rates for each PM #04 is reported on a monthly basis. Three HEDIS measures and one MLTSS specific measure (PM #47) were reported annually. All other PMS were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

The following are the measures for validation, showing the New Jersey MLTSS Performance Measure number associated with the measure for WYE 2022 (7/1/21-6/30/22):

1. PM #04 – Timeliness of Nursing Facility Level of Care Assessment by MCO (Monthly)

The following measures are monitored quarterly and reviewed annually:

1. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.
2. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
3. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
4. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
5. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
6. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
7. PM #21 – MLTSS Members who Transitioned from NF to the Community
8. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
9. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
10. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
11. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
12. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
13. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
14. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
15. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
16. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
17. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
18. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
19. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
20. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
21. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
22. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
23. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
24. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
25. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)

26. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
27. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
28. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
29. PM #52* – Care for Older Adults for MLTSS Members (HEDIS COA)
30. PM #53* - Care of Older Adults for NF Members (HEDIS COA)

WYE 2023 MLTSS Performance Measures

Specifications were updated in 2022 for the July 2022 through June 2023 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member level files, and rates for each MCO. PM #04 was reported on a monthly basis. Four HEDIS measures and one MLTSS specific measure (PM #47) were reported annually. All other PMS were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

The following are the measures for validation, showing the New Jersey MLTSS Performance Measure number associated with the measure for WYE 2023 (7/1/22-6/30/23):

1. PM #04 – Timeliness of Nursing Facility Level of Care Assessment by MCO (Monthly)

The following measures are monitored quarterly and reviewed annually:

1. HPM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.
2. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
3. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
4. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
5. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
6. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
7. PM #21 – MLTSS Members who Transitioned from NF to the Community
8. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
9. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
10. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
11. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
12. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
13. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
14. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
15. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
16. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
17. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
18. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
19. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only

20. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
21. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
22. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
23. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
24. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
25. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
26. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
27. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
28. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
29. PM #52* – Care for Older Adults for MLTSS Members (HEDIS COA)
30. PM #53* - Care of Older Adults for NF Members (HEDIS COA)
31. PM #54a – New MLTSS members receiving PCA, MDC, and or MLTSS services

PM #54b* - New MLTSS HCBS Members receiving PCA, MDC, and/or MLTSS Services

Validation Results of MLTSS Performance Measures

The final validation report for WYE 2022 is in progress and will be reflected in next year's ATR.

2022 MLTSS Performance Measure #13

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

In 2022, the validation of PM #13 for measurement period from July 2020 to June 2021 continued. For the measurement period July 2020 to June 2021, members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2020, and June 30, 2021.

For the measurement period (July 2020 to June 2021) samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The final PM#13 reports are ongoing and will be submitted to DMAHS in May 2023. The Evaluation, Methodology Conclusions and Comparative Findings will be presented in the next ATR in 2024.

2022 MLTSS Service Delivery Project

MLTSS Service Delivery evaluates compliance of the delivery of four specific MLTSS services, in accordance with the MLTSS members' Plan of Care (POCs) for Home and Community Based Services (HCBS) members for NJ Medicaid and FIDE SNP MCOs. The four services are: Home Delivered Meals (HDM), Medical Day Care (MDC), Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). Evaluation of POC compliance with service delivery is based on type, scope, amount, frequency, and duration of service. In

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

In 2022, the MLTSS Service Delivery project was based on the measurement period January 1, 2020 through December 31, 2020. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 and was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. IPRO developed an algorithm, to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

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

Evaluation Methodology

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

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

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

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

- PM #8
  IPRO requested initial enrollment date into MLTSS for the samples selected. PM #8 requires that the member be newly enrolled in MLTSS during the review period. The MLTSS Service Delivery samples were augmented to include sufficient cases from each MCO to ensure a sample of 120 cases for each MCO for PM #8.
- PM #10 and PM #11
  In addition to the POCs submitted for the MLTSS Service Delivery samples, IPRO requested copies of the New Jersey Choice Assessment for each member in the sample. This information was used to evaluate MCO compliance with PM #10. Compliance with PM #11 was determined based on a review of the POCs submitted for MLTSS Service Delivery.

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

Conclusions and Comparative Findings

The Final Report is in process. The following are the preliminary rates and conclusions. As shown in **Table 32**, a total of 1,491 cases were sampled from the authorizations across all MCOs. For each MCO, an algorithm was used to minimize the number of unique cases required to ensure that there were 120 cases for each service type and PM #8. Sample sizes varied by MCO.

Table 32: MLTSS Service Delivery Sample Summary

MCO:	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Total
Unique cases sampled	339	265	416	289	182	1,491

Table 33 presents service rates by MCO and for the overall sample. The overall percentages of service delivery versus expected services ranges from 68% of Home Delivered Meals to 89% of PERS. For all MCOs, Home Delivered Meals has the lowest rate, while PERS shows the highest delivery rate for 3 of the 5 MCOs. Among the MCOs, ABHNJ has the best performance with highest rate for Medical Day and HNJH has the best performance with highest rate for PERS.

Table 33: Rate of Service Delivery Versus Planned Amount

MCO	Home Delivered Meals	Medical Day	PCA	PERS
ABHNJ	81%	93%	82%	88%
AGNJ	79%	88%	81%	89%
HNJH	81%	83%	82%	93%
UHCCP	71%	75%	76%	89%
WCHP	22%	89%	72%	86%
Statewide[1]	68%	85%	79%	89%

[1] The statewide rate is the weighted average of the MCO rates, as **Table 34** illustrates.

Table 34 presents a summary based on file review of the MCOs' performance for the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS HCBS), #10 (Plans of Care are aligned with member needs based on the results of the NJ Choice Assessment), and #11 (Plans of Care developed using "person-centered principles").

Table 34: Results of Performance Measures

Performance Measure	MCO	Denominator	Numerator	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[1]	ABHNJ	120	78	65%
	AGNJ	120	103	86%
	HNJH	120	98	82%
	UHCCP	120	69	58%
	WCHP	120	77	64%
	Total	600	425	71%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[2]	ABHNJ	41	38	93%
	AGNJ	85	42	49%
	HNJH	50	47	94%
	UHCCP	55	35	64%
	WCHP	61	61	100%
	Total	292	223	76%
#11. Plans of Care developed using "person-centered principles"[3]	ABHNJ	120	102	85%
	AGNJ	120	113	94%
	HNJH	120	120	100%
	UHCCP	120	107	89%
	WCHP	120	120	100%
	Total	600	562	94%

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

The overall performance rates for PM #8, PM #10, and PM #11 ranged from 71% to 94%.

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

Objectives

Results from the HEDIS-CAHPS 2022 5.1H Surveys for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following two survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare MCOs: Center for the Study of Services (CSS) and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2021, through December 31, 2021, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

Technical Methods of Data Collection and Analysis

The survey drew, as potential respondents, adult enrollees over the age of 18 years, and children under the age of 18 years who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2022 using a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. All five health plans utilized a mail and telephone protocol. Additionally, ABHNJ, HNJH and UHCCP offered the option to complete the survey via the internet. For the Child CAHPS survey, ABHNJ opted to send a third survey mailing to those who had not responded to the first two mailings.

Description of Data Obtained and Conclusion

For the adult survey, a total random sample of 7,695 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,350 ABHNJ enrollees, 1,350 AGNJ enrollees, 1,755 HNJH enrollees, 1,890 UHCCP enrollees, and 1,350 WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,187 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 15.6%, which was a decrease from the previous year's response rate of 18.7%. Composite results of the adult NJ FamilyCare overall weighted responses for the five MCOs were: 91.9% for how well doctors communicate; 87.9% for customer service; 79.5% for getting needed care; and 75.5% for getting care quickly.

For the child survey, a total random sample of 10,610 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 2,772 ABHNJ enrollees, 1,733 AGNJ enrollees, 2,475 HNJH enrollees, 1,980 UHCCP enrollees, and 1,650 WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,906 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 18.2%, which was a decrease from the previous year's response rate of 21.5%. The composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 91.9% for how well doctors communicate; 86.7% for customer service; 78.8% for getting needed care; and 74.5% for getting care quickly.

For the CHIP survey, a total random sample of 2,145 parent/caretakers of CHIP child enrollees was drawn. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 484 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 22.8%, which was a decrease from last year's response rate of 29.5%. Composite results of the CHIP NJ

FamilyCare overall statewide responses were: 95.0% for how well doctors communicate; 87.0% for customer service; 83.9% for getting needed care; and 73.2% for getting care quickly.

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 35**.

Table 35: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2021 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2021 Quality Compass National Percentiles
Orange	Less than 25th percentile
Yellow	Greater than or equal to 25th and less than 50th percentile
Green	Greater than or equal to 50th and less than 75th percentile
Blue	Greater than or equal to 75th and less than 90th percentile
Purple	Great than or equal to the 90th percentile

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

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all MCOs, IPRO compared the NJ FamilyCare overall Statewide weighted averages for adults and children (**Table 36** and **Table 37**) to the national Medicaid benchmarks presented in the MY 2021 *Quality Compass*. Measures performing at or above the 75th percentile and below the 90th percentile were considered strengths; measures performing at the 50th percentile and below the 75th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Table 36: CAHPS MY 2021 Performance – Medicaid Adult Survey

Adult Survey – CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Statewide Weighted Average
Getting Needed Care	82.8%	82.2%	77.6%	81.6%	83.0%	79.5%
Getting Care Quickly	78.7%	82.8%	73.0%	77.4%	77.1%	75.5%
How Well Doctors Communicate	94.6%	91.2%	91.1%	92.8%	95.2%	91.9%
Customer Service	88.5%	88.1%	87.7%	87.1%	90.3%	87.9%
Rating of All Health Care[1]	74.6%	78.9%	76.4%	75.1%	76.1%	76.3%
Rating of Personal Doctor[1]	81.4%	83.1%	81.2%	79.3%	86.0%	81.4%
Rating of Specialist Seen Most Often[1]	74.6%	84.2%	90.9%	87.1%	84.4%	88.2%
Rating of Health Plan[1]	75.4%	76.2%	83.9%	75.0%	80.8%	80.7%

[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 MY 2021 Quality Compass national percentiles: orange shading – less than 25th percentile; yellow shading – greater than or equal to 25th and less than 50th percentile; green shading is greater than or equal to 50th and less than 75th percentile; blue shading – greater than or equal to 75th and less than 90th percentile; purple shading – greater than or equal to the 90th percentile.

Table 37: CAHPS MY 2021 Performance – Medicaid Child Survey

Child Survey – CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP	Statewide Weighted Average
Getting Needed Care	80.7%	81.4%	77.2%	81.9%	77.3%	78.8%
Getting Care Quickly	80.5%	85.0%	69.8%	79.6%	69.9%	74.5%
How Well Doctors Communicate	92.4%	93.4%	91.0%	93.0%	92.3%	91.9%
Customer Service	88.0%	86.3%	86.5%	86.6%	88.6%	86.7%
Rating of All Health Care	84.8%	86.2%	82.5%	82.0%	83.3%	83.1%
Rating of Personal Doctor[1]	86.7%	91.6%	85.4%	88.2%	90.4%	87.0%
Rating of Specialist Seen Most Often[1]	83.9%	84.6%	78.9%	90.5%	82.9%	82.4%
Rating of Health Plan[1]	75.7%	83.2%	86.0%	83.9%	84.6%	84.7%

[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 MY 2021 Quality Compass national percentiles: orange shading – less than 25th percentile; yellow shading – greater than or equal to 25th and less than 50th percentile; green shading is greater than or equal to 50th and less than 75th percentile; blue shading – greater than or equal to 75th and less than 90th percentile; purple shading – greater than or equal to the 90th percentile.

Weighted statewide average rates ranked at or above the NCQA national 50th percentile for 3 of the 8 adult measures (**Table 36**). Opportunities for improvement are evident for the five adult measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service and Rating of Personal Doctor). Opportunities for improvement are evident for all eight (8) Child measures (**Table 37**).

For the Adult survey measures, HNJH had one (1) measure above the national 90th percentile, and two (2) measures greater than or equal to 50th percentile (**Table 36**). AGNJ had four (4) measures greater than or equal to 50th percentile, followed by ABHNJ and UHCCP with one (1) measure greater than or equal to 50th percentile (**Table 36**). WCHP had seven (7) measures greater than or equal to 50th percentile.

For the Child survey measures, ABHNJ, AGNJ and WCHP had one (1) measure above the 50th national percentile (**Table 37**). UHCCP had one (1) measure above the national 90th percentile. All MCOs had five (5) Child rates at or below the national 50th percentile: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care and Rating of Health Plan (**Table 37**).

VII. Care Management Audits

2022 Core Medicaid Care Management Audits

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

In 2021 and 2022, IPRO, and OQA collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions were limited to exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether Enrollees met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

The MY 2021 rates across all MCOs, populations, and categories ranged from 29% to 100%. Scores for Identification ranged from 57% to 81% for the General Population. Outreach ranged from 57% to 100% for all MCOs for all populations (GP, DDD and DCP&P). Scores for the Preventive Services Category ranged from 29% to 81% across all MCOs for all populations. Scores for Continuity of Care ranged from 47% to 100% across all MCOs for all populations. Scores for Coordination of Services ranged from 41% to 100% across all MCOs for all populations.

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

Assessment Methodology

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

Summary of Core Medicaid Care Management Audit Performance

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 38, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 38: Core Medicaid Care Management Summary of Performance

Determination by Category	MCO				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
	MY 2021	MY 2021	MY 2021	MY 2021	MY 2021
GP	n = 100	n = 100	n = 100	n = 100	n = 100
Identification[1]	68%	60%	57%	81%	80%
Outreach	63%	64%	57%	83%	82%
Preventive Service	38%	29%	62%	42%	35%
Continuity of Care	59%	47%	52%	65%	73%
Coordination of Services	73%	41%	72%	78%	78%
DDD	n =28	n =17	n =71	n =18	n =23
Outreach	98%	100%	97%	100%	96%
Preventive Service	66%	76%	69%	73%	69%
Continuity of Care	91%	90%	81%	83%	90%
Coordination of Services	98%	100%	100%	100%	94%
DCP&P	n =37	n =35	n =86	n =34	n =17
Outreach	100%	100%	99%	100%	82%
Preventive Service	71%	81%	69%	70%	73%
Continuity of Care	93%	99%	100%	100%	91%
Coordination of Services	99%	100%	100%	100%	100%

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

ABHNJ's 2022 audit results ranged from 38% to 100% across all populations for the five audit categories.

AGNJ's 2022 audit results ranged from 29% to 100% across all populations for the five audit categories.

HNJH's 2022 audit results ranged from 52% to 100% across all populations for the five audit categories.

UHCCP's 2022 audit results ranged from 42% to 100% across all populations for the five audit categories.

WCHP's 2022 audit results ranged from 35% to 100% across all populations for the five audit categories.

Compliance threshold in an audit category is 85% or above.

Core Medicaid Care Management and Continuity of Care Annual Assessment

Assessment Methodology

The Care Management and Continuity of Care review examines if the MCO has an effective Care and Case Management service structure. This structure includes written policies, procedures, processes and systems to identify, assess and manage its Enrollee population in Care and Case Management Program(s). This review also examines whether the MCO has developed and implemented Care and Case Management Programs for all Enrollees who may benefit from these services in accordance with State requirements. These programs should utilize the Initial Health Screening (IHS) outreach for all new Enrollees in the General Population and the Comprehensive Needs Assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate

level of service for Enrollees with special needs or those in the General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The 2022 Care Management assessment covered the period from January 1, 2021, to December 31, 2021. Interviews with key MCO staff were held via WebEx in May 2022.

There are 30 contractual elements in the 2022 assessment. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the 2022 Core Medicaid file review. Overall compliance scores for the five MCOs ranged from 73% to 83%. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 39** presents an overview of the results by MCO.

Table 39: Summary of Findings for 2022 Core Medicaid Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	30	24	6	80%
AGNJ	30	23	7	77%
HNJH	30	25	5	83%
UHCCP	30	22	8	73%
WCHP	30	24	6	80%

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

Table 40 presents the summary of findings for the Core Medicaid Care Management Continuity of Care elements reviewed in 2022. Complete findings and IPRO's recommendations for each MCO can be located in **Appendices B–F.**

Table 40: Summary of Findings for Core Medicaid Care Management and Continuity of Care

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	WCHP Met
CM1	X	X	X	X	X
CM2	-	-	X	-	-
CM3	-	-	-	-	-
CM4	X	X	X	X	X
CM5	X	X	X	X	X
CM6	-	-	X	-	-
CM7	-	-	-	-	-
CM8	X	-	-	-	X
CM9	X	X	X	X	X
CM10	X	X	X	X	X

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	WCHP Met
CM11	X	X	X	X	X
CM12	X	X	X	X	X
CM13	X	X	X	-	X
CM14	-	-	-	-	-
CM15	X	X	X	X	X
CM16	X	X	X	X	X
CM17	X	X	X	X	X
CM18a	X	X	X	X	X
CM18c	X	X	X	X	X
CM18d	X	X	X	X	X
CM19	-	-	-	-	-
CM20	X	X	X	X	X
CM21	X	X	X	X	X
CM22	X	X	X	X	X
CM23	X	X	X	X	X
CM24	X	X	X	X	X
CM25	X	X	X	X	X
CM26	X	X	X	X	X
CM27	X	X	X	X	X
CM37	X	X	X	X	X
Total	**24**	**23**	**25**	**22**	**24**
Compliance Percentage	**80%**	**77%**	**83%**	**73%**	**80%**

None of the MCOs met the compliance threshold of 85% or above. All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in **Section XI** and also in **Appendices B-F**.

2022 MLTSS Nursing Facility Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30. Due to COVID-19, the prior review period was from July 1, 2019, through February 29, 2020. An expansion period was included from March 1, 2020, through December 31, 2020, to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was January 1, 2021, through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the state of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 and August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

Pre-Audit Planning Activities

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. For some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

The audit review tool was significantly revised for the 2022 audit, therefore, comparisons to prior years are not supported. Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

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

In order to collect additional information for MLTSS Members who transitioned between HCBS and a NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups as indicated in **Table 41**.

Table 41: MLTSS NF/SCNF Population Subgroups

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between January 1, 2021, and August 14, 2021, with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021, and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021, and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021, and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months and transitioned back to HCBS for at least one month during the review period

The 2022 MLTSS NF/SCNF Audit Results are presented in **Table 42**.

Table 42: 2022 MLTSS NF/SCNF Audit Results

Category	1/1/21 – 8/14/21 Total Rates															
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
Facility and MCO Plan of Care																
Member's care management record contained copies of any facility plans of care on file during the review period	70	100	70.0%	75	100	75.0%	64	100	64.0%	21	100	21.0%	64	100	64.0%	58.8%
Documented review of the facility plan of care by the care manager	68	70	97.1%	75	75	100.0%	64	64	100.0%	20	21	95.2%	60	64	93.8%	97.6%
MLTSS plan of care on file includes information from the facility plan of care	69	70	98.6%	75	75	100.0%	63	64	98.4%	19	21	90.5%	55	64	85.9%	95.6%
MLTSS Initial Plan of Care and Ongoing Plans of Care																
The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (applies to Members newly enrolled in MLTSS and admitted to the Nursing Facility between 7/1/2019 and 9/1/2019)	3	4	75.0%	3	4	75.0%	1	6	16.7%	0	5	0.0%	1	2	50.0%	38.1%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	89	100	89.0%	100	100	100.0%	99	100	99.0%	77	100	77.0%	77	100	77.0%	88.4%
Care Manager arranged Plan of Care services using both formal and informal supports.	93	100	93.0%	100	100	100.0%	99	100	99.0%	77	100	77.0%	77	100	77.0%	89.2%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	89	100	89.0%	100	100	100.0%	99	100	99.0%	77	100	77.0%	77	100	77.0%	88.4%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	94	100	94.0%	100	100	100.0%	99	100	99.0%	77	100	77.0%	77	100	77.0%	89.4%

Category	1/1/21 – 8/14/21 Total Rates															
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record.	89	100	89.0%	100	100	100.0%	99	100	99.0%	76	100	76.0%	67	100	67.0%	86.2%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	1	0.0%	0	1	0.0%	0	2	0.0%	0	1	0.0%	0	0	CNC	CNC
Transition Planning																
Member was identified for transfer to HCBS and was offered options, including transfer to the community	89	100	89.0%	100	100	100.0%	100	100	100.0%	79	100	79.0%	79	100	79.0%	89.4%
Evidence of the Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting during the review period. (Participation in an IDT meeting may be substituted for one Member visit)	14	100	14.0%	2	100	2.0%	8	100	8.0%	3	100	3.0%	7	100	7.0%	6.8%
Member was present at each telephonic visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	92	100	92.0%	100	100	100.0%	100	100	100.0%	85	100	85.0%	83	100	83.0%	92.0%
Timely Telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF embers or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	36	100	36.0%	95	100	95.0%	100	100	100.0%	80	100	80.0%	78	100	78.0%	77.8%
Members requiring coordination of care had coordination of care by the Care Manager	96	100	96.0%	98	100	98.0%	100	100	100.0%	91	100	91.0%	99	100	99.0%	96.8%
Care Manager explained and discussed any payment liability with the member	57	100	57.0%	6	100	6.0%	55	100	55.0%	66	100	66.0%	75	100	75.0%	51.8%
Reassessment of the POC and Critical Incident Reporting																
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	0	0	CNC	CNC
Plan of Care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	89	100	89.0%	98	100	98.0%	99	100	99.0%	76	100	76.0%	76	100	76.0%	87.6%
Care Manager reviewed the Member's Rights and	89	100	89.0%	100	100	100.0%	99	100	99.0%	78	100	78.0%	78	100	78.0%	88.8%

Category	1/1/21 – 8/14/21 Total Rates															
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
Responsibilities																
Care Manager educated the Member on how to file a grievance and/or an appeal	89	100	89.0%	100	100	100.0%	99	100	99.0%	78	100	78.0%	78	100	78.0%	88.8%
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation	89	100	89.0%	99	100	99.0%	96	100	96.0%	76	100	76.0%	78	100	78.0%	87.6%
PASRR Communication for Transitions to/from NF/SCNF																
Member was admitted to a NF/SCNF prior to the review period*	N/A			N/A			N/A			N/A			N/A			CNC
Member was admitted to an NF/SCNF during the review period*	N/A			N/A			N/A			N/A			N/A			CNC
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CNC
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CNC
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CNC
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CNC
Members who had PASSR Level II forms indicating a need for Specialized Services Setting was coordinated appropriately with DDD/DMHAS	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CNC

*Element not scored.
CNC: Could not calculate.
N/A: Not applicable.

As seen in **Table 42**, for the review period January 1, 2021, through August 14, 2021, none of the five MCOs scored at or above 86% for "MLTSS Plans of Care on file" and three of the five MCOs scored at or above 86% for "Members present at each telephonic visit"; three of the five MCOs scored at or above 86%, for "Members identified for transfer to HCBS"; three of the five MCOs scored at or above 86%, for Member and/or representative participated in the development of goals."

Only four members across all five MCOs met criteria for evaluation of PASRR elements (**Table 42**). Excluding these elements, 21 individual elements were evaluated across all five MCOs. Two of the five MCOs scored at or above 86% for 15 or more elements: AGNJ scored at or above 86% for 15 elements; and HNJH scored at or above 86% for 15 elements. ABHNJ score at or above 86% for only 14 elements; UHCCP scored at or above 86% for only 3 elements; and WCNJ scored at or above 86% for only 2 elements. Individual recommendations were provided to the MCOs with their final report.

Results of MLTSS NF Performance Measures

Beginning in 2021, the NF audit included evaluating the NF/SCNF Population on the MLTSS Performance Measures. Population-specific findings by MCO in **Table 43** present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents).

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

Table 43: Results of MLTSS NF/SCNF Performance Measures – January 1, 2021 – August 14, 2021

Performance Measure	Group	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	75.0%	75.0%	16.7%	0.0%	50.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**75.0%**	**75.0%**	**16.7%**	**0.0%**	**50.0%**
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	89.0%	100.0%	99.0%	78.0%	78.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**89.0%**	**100.0%**	**99.0%**	**78.0%**	**78.0%**
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0.0%	0.0%	0.0%	0.0%	CNC
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**CNC**
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	89.0%	100.0%	99.0%	77.0%	77.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CCN	CNC
	Total	**89.0%**	**100.0%**	**99.0%**	**77.0%**	**77.0%**

Performance Measure	Group	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
#16. Member training on identifying/reporting critical incidents	Group 1	89.0%	99.0%	96.0%	76.0%	78.0%
	Group 2	CNC	CNC	CNC	CNC	CNC
	Group 3	CNC	CNC	CNC	CNC	CNC
	Group 4	CNC	CNC	CNC	CNC	CNC
	Total	**89.0%**	**99.0%**	**96.0%**	**76.0%**	**78.0%**

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

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

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

ABHNJ's MLTSS NF/SCNF Audit Results

Overall, ABHNJ scored 86% or above in the following review elements (Table 42):

- Documented Review of the Facility Plan of Care (97.1%)
- MLTSS Plan of Care on file (98.6%)
- Care Managers used a person-centered approach (89.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (93.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (89.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (94.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (89.0%)
- Member was identified for transfer to HCBS and was offered options including transfer to the community (89.0%)
- Member was present at each telephonic visit (92.0%)
- Members requiring coordination of care had coordination of care (96.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (89.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (89.0%)
- Member and/or representative had training on how to report a critical incident (89.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 42):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period file (70.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for members newly enrolled in MLTSS.) program (75.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (14.0%)
- Timely Telephonic Review of Member Placement and Services (36.0%)
- Care Manager explained and discussed any payment liability (57.0%)

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 43):

- PM #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (89.0%)
- PM #11 POC Developed Using "Person Centered Principles" (89.0%)
- PM #16 Member Training on Identifying/Reporting Critical Incidents (89.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 43):

- PM #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (75.0%)
- PM #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

AGNJ's MLTSS NF/SCNF Audit Results

Overall, AGNJ scored 86% or above in the following review elements (Table 42):

- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (100.0%)
- Care Managers used a person-centered approach (100.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (100.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (100.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (100.0%)
- Member was identified for transfer to HCBS and was offered options (100.0%)
- Member was present at each telephonic visit (100.0%)
- Timely Telephonic Review of Member Placement and Services (95.0%)
- Members requiring coordination of care had coordination of care (98.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (98.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100.0%)
- Member and/or representative had training on how to report a critical incident (99.0%)

AGNJ's Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 42):

- Copies of any Facility Plans of Care on file (75.0%)

- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (75.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (2.0%)
- Care Manager explained and discussed any payment liability (6.0%)

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 43):

- PM #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as PM #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (75.0%)
- PM #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

HNJH's MLTSS NF/SCNF Audit Results

Overall, HNJH scored 86% or above in the following review elements (Table 42):

- Documented Review of the Facility Plan of Care (100.0%)
- MLTSS Plan of Care on file (98.4%)
- Care Managers used a person-centered approach (99.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (99.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (99.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (99.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (99.0%)
- Member was identified for transfer to HCBS and was offered options (100.0%)
- Member was present at each telephonic visit (100.0%)
- Timely Telephonic Review of Member Placement and Services (100.0%)
- Members requiring coordination of care had coordination of care (100.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (99.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (99.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (99.0%)
- Member and/or representative had training on how to report a critical incident (96.0%)

HNJH's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 42):

- Copies of any Facility Plans of Care on file (64.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (16.7%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (8.0%)
- Care Manager explained and discussed any payment liability (55.0%)

Strengths for MLTSS Performance Measures that scored at or above 86% (Table 43):

- PM #9 POC Reviewed Annually within 30 days of Anniversary and as Necessary (99.0%)
- PM #11 POC Developed Using "Person Centered Principles" (99.0%)
- PM #16 Member Training on Identifying/Reporting Critical Incidents (96.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 43):

- PM #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (16.7%)
- PM #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

UHCCP's MLTSS NF/SCNF Audit Results

Overall, UHCCP scored 86% or above in the following review elements (Table 42):

- Documented Review of the Facility Plan of Care (95.2%)
- MLTSS Plan of Care on file (90.5%)
- Members requiring coordination of care had coordination of care (91.0%)

UHCCP's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 42):

- Copies of any Facility Plans of Care on file (21.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (0.0%)
- Care Managers used a person-centered approach (77.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (77.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (77.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (77.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (76.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Member was identified for transfer to HCBS and was offered options (79.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (3.0%)
- Member was present at each telephonic visit (85.0%)
- Timely Telephonic Review of Member Placement and Services (80.0%)
- Care Manager explained and discussed any payment liability (66.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (76.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (78.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (78.0%)
- Member and/or representative had training on how to report a critical incident (76.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 43):

- PM #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (0.0%)
- PM #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (78.0%)
- PM #9a. Member's Plan of Care is amended based on change of member condition (0.0%)
- PM #11. Plans of Care developed using "person-centered principles (77.0%)
- PM #16. Member training on identifying/reporting critical incidents (76.0%)

WCHP's MLTSS NF/SCNF Audit Results

Overall, WCHP scored 86% or above in the following review elements (Table 42):

- Documented Review of the Facility Plan of Care (93.8%)

- Members requiring coordination of care had coordination of care (99.0%)

WCHP's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 42):

- Copies of any Facility Plans of Care on file (64.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (50.0%)
- Care Managers used a person-centered approach (77.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (77.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (77.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (77.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (67.0%)
- MLTSS Plan of Care on file (85.9%)
- Member was identified for transfer to HCBS and was offered options (79.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (7.0%)
- Member was present at each telephonic visit (83.0%)
- Timely Telephonic Review of Member Placement and Services (78.0%)
- Care Manager explained and discussed any payment liability (75.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (76.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (78.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (78.0%)
- Member and/or representative had training on how to report a critical incident (78.0%)

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (Table 43):

- PM #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (50.0%)
- PM #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (78.0%)
- PM #11. Plans of Care developed using "person-centered principles (77.0%)
- PM #16. Member training on identifying/reporting critical incidents (78.0%)

2022 MLTSS HCBS Care Management Audits

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management Activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were

removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The sampling methodology as shown in **Table 44** resulted in the total selection of 110 cases for Aetna Better Health of New Jersey (Aetna), 110 cases for Amerigroup New Jersey, Inc. (Amerigroup), 110 cases for Horizon NJ Health (Horizon), 110 cases for UnitedHealthcare Community Plan (United), and 110 cases for WellCare Health Plans of New Jersey, Inc. (WellCare), including an oversample.

Table 44: Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 10/26/2021. A sample of 50 high-risk cases with an oversample of four cases was drawn for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents Screening for Community Services Assessment and contract references. In 2019 and 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the

criteria for a subsequent section or question. Therefore, for some audit questions members represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment and applying the sampling methodology described in **(Table 44).**

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

MLTSS HCBS Results by Category

Table 45 presents a summary based on file review of the MCOs' performance. Based on the audit tool, there were six categories of review elements (Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing CM and Gaps in Care). The results of individual review elements under each topic were calculated and rolled-up to produce a compliance score for each category.

The following MCOs scored a total of 86% or above for all (3) MLTSS subpopulations for the following Performance Measures:

- Assessment: Amerigroup and Horizon
- Member Outreach: Amerigroup and Horizon
- Telephonic Monitoring or Face-to-Face Visits: Amerigroup, Horizon and WellCare
- Initial Plan of Care (Including Back-up Plans): Aetna, Amerigroup, Horizon and WellCare
- Ongoing Care Management: Amerigroup and Horizon
- Gaps in Care/Critical Incidents: Aetna, Amerigroup, Horizon and WellCare

The following MCOs scored below 86% in the subpopulations for the following Performance Measures:

- Assessment: Aetna, United Healthcare, and WellCare
- Member Outreach: Aetna, United Healthcare, and WellCare
- Telephonic Monitoring or Face-to-Face Visits: Aetna and United Healthcare
- Initial Plan of Care (Including Back-up Plans): United Healthcare
- Ongoing Care Management: Aetna, United Healthcare, and WellCare
- Gaps in Care/Critical Incidents: United Healthcare

Table 45: 2022 MLTSS HCBS Results by Category

Determination by Category 8/15/2021 – 6/30/2022	AETNA				AMERIGROUP				HORIZON				UNITED				WELLCARE				NJ Weighted Average[1]
	Group				Group				Group				Group				Group				
	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	
Assessment[2]		40.5%		40.5%		95.8%		95.8%		100.0%		100.0%		57.1%		57.1%		43.2%		43.2%	68.7%
Member Outreach[3]	92.0%	56.0%		74.0%	76.0%	100.0%		88.0%	92.0%	88.0%		90.0%	36.0%	68.0%		52.0%	60.0%	80.0%		70.0%	74.8%
Telephonic Monitoring (Formerly Face-to-Face) Visits	69.1%	74.1%	70.1%	70.9%	92.8%	92.9%	85.2%	89.0%	96.5%	93.3%	91.6%	93.3%	59.4%	73.0%	72.2%	69.2%	89.7%	92.1%	85.0%	87.9%	82.1%
Initial Plan of Care (Including Back-up Plans)	88.3%	84.0%	94.8%	90.7%	88.2%	85.1%	89.4%	88.0%	92.3%	91.0%	95.7%	93.8%	47.2%	64.7%	58.1%	57.5%	80.2%	86.4%	90.0%	86.9%	84.1%
Ongoing Care Management	64.9%	58.7%	53.8%	58.1%	83.9%	91.5%	85.2%	86.7%	91.1%	89.9%	96.3%	93.1%	36.4%	52.7%	35.4%	40.9%	39.6%	50.0%	37.1%	41.4%	63.0%
Gaps in Care/Critical Incidents	96.1%	92.2%	95.2%	94.7%	96.2%	100.0%	100.0%	99.0%	100.0%	100.0%	99.0%	99.5%	68.0%	84.3%	90.0%	83.1%	80.0%	100.0%	99.0%	94.5%	94.2%

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

Group D - Current Members Newly Enrolled to MLTSS.

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

[1]The weighted average is the sum of all numerators compliant charts divided by the sum of all charts in the denominator and include all three subpopulations.
[2]MLTSS Assessment is not performed for members in Group C and Group E because they are already enrolled in MLTSS.
[3]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.

Table 45 contains individual MCO's aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring (formerly Face-to-Face) Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's audit results for the combined MLTSS sample ranged from 40.5% to 94.7% across all three (3) populations for the six (6) audit categories.

AGNJ's audit results for the combined MLTSS sample ranged from 86.7% to 99% across all three (3) populations for the six (6) audit categories.

HNJH's audit results for the combined MLTSS sample ranged from 90% to 100% across all three (3) populations for the six (6) audit categories.

UHCCP's audit results for the combined MLTSS sample ranged from 40.9% to 83.1% across all three (3) populations for the six (6) audit categories.

WCHP's audit results for the combined MLTSS sample ranged from 41.4% to 94.5% across all three (3) populations for the six (6) audit categories.

Strengths and Opportunities for Improvement

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

ABHNJ

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

- Member Outreach (Group C)
- Initial Plan of Care (Including Back-up Plans) (Groups C and E)
- Gaps in Care/Critical Incidents (Groups C, D, and E)

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

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

AGNJ

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

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

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

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

HNJH

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

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

UHCCP

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

- Gaps in Care/Critical Incidents (Group E)

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

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

WCHP

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

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

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

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

2022 MLTSS HCBS Performance Measures Findings

In review of this year's total scores that include all three (3) MLTSS subpopulations (August 2021 – June 2022), individual MCO results ranged from 17.4% to 100.0% across all five (5) MLTSS Performance Measures (**Table 46).**

The MCOs scored at 86% or above at the total level, for all applicable MLTSS subpopulations for the following Performance Measures:

- PM #9a. Member's Plan of Care is amended based on change of member condition – Aetna, Amerigroup, and Horizon.
- PM #10 Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment – Amerigroup, Horizon, and Wellcare.
- PM #11. Plans of Care developed using "Person-Centered Principles" – Aetna, Amerigroup, Horizon, and WellCare.
- PM #12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan – Aetna, Amerigroup, Horizon, and WellCare.
- PM #16. Member training on identifying/reporting critical incidents –Aetna, Amerigroup, Horizon, and WellCare.

The MCOs scored below 86% at the total level, for all applicable MLTSS subpopulations for the following Performance Measures:

- PM #9a. Member's Plan of Care is amended based on change of Member condition - WellCare and United Healthcare.
- PM #10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment - Aetna and United Healthcare.
- PM #11. Plans of Care developed using "Person-Centered Principles" - United Healthcare.
- PM #12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan - United Healthcare.
- PM #16. Member training on identifying/reporting critical incidents - United Healthcare.

Table 46: 2022 MLTSS HCBS Performance Measures

Performance Measure	Group[1]	ABHNJ 8/15/2021 to 6/30/2022	AGNJ 8/15/2021 to 6/30/2022	HNJH 8/15/2021 to 6/30/2022	UHCCP 8/15/2021 to 6/30/2022	WCHP 8/15/2021 to 6/30/2022	NJ Weighted Average[7] 8/15/2021 to 6/30/2022
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	C						
	D						
	E						
	Total						
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	C						
	D						
	E						
	Total						

Performance Measure	Group[1]	ABHNJ 8/15/2021 to 6/30/2022	AGNJ 8/15/2021 to 6/30/2022	HNJH 8/15/2021 to 6/30/2022	UHCCP 8/15/2021 to 6/30/2022	WCHP 8/15/2021 to 6/30/2022	NJ Weighted Average[7] 8/15/2021 to 6/30/2022
#9a. Member's Plan of Care is amended based on change of member condition[3]	C	100.0%	100.0%	100.0%	N/A	0.0%	85.7%
	D	100.0%	100.0%	100.0%	50.0%	N/A	92.9%
	E	100.0%	100.0%	100.0%	100.00	100.0%	100.0%
	Total	100.0%	100.0%	100.0%	66.7%	50.0%	95.0%
#10 Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	C	76.2%	100.0%	100.0%	43.8%	91.7%	85.5%
	D	95.0%	100.0%	100.0%	81.8%	100.0%	95.5%
	E						
	Total	85.4%	100.0%	100.0%	65.8%	95.8%	90.5%
#11. Plans of Care developed using "person-centered principles"[5]	C	66.7%	100.0%	100.0%	38.9%	100.0%	83.3%
	D	91.3%	100.0%	100.0%	78.3%	100.0%	94.2%
	E	93.9%	98.0%	100.0%	30.0%	90.0%	82.3%
	Total	86.5%	99.0%	100.0%	44.0%	94.8%	85.5%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	C	94.4%	100.0%	100.0%	20.0%	94.1%	80.6%
	D	81.0%	100.0%	100.0%	52.2%	96.0%	86.1%
	E	94.0%	100.0%	98.0%	0.0%	100.0%	78.6%
	Total	91.0%	100.0%	98.9%	17.4%	97.8%	80.9%
#16. Member training on identifying/reporting critical incidents	C	96.0%	100.0%	100.0%	72.0%	96.0%	92.8%
	D	92.0%	100.0%	100.0%	88.0%	100.0%	96.0%
	E	98.0%	100.0%	100.0%	82.0%	100.0%	96.0%
	Total	96.0%	100.0%	100.0%	81.0%	99.0%	95.2%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]This measure was not calculated during this review
[3]Members who did not have a documented change in condition during the study period are excluded from this measure
[4]Group E Members are excluded from this measure
[5]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[6]Members in CARS are excluded from this measure
[7]The weighted average is the sum of all compliant charts (numerator) divided by the sum of all charts (denominator) and include all three subpopulations
N/A: Not applicable

Return to Field MLTSS HCBS Focus Study

In 2022, at the request of DMAHS, in conjunction with the 2022 MLTSS HCBS audit, IPRO developed a focus study on the Return to Field for the MLTSS HCBS population to evaluate the MCO's compliance with the Department of Medical Assistance and Services (DMAHS) Return to Field guidance dated August 11, 2021.

DMAHS provided the MCOs with the Care Management Visit Guidance on August 11, 2021. The guidance outlined the phase in requirements for the MCO's to conduct Care Management visits for all members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022, as well as those enrolled in populations where face-to-face visits are applicable.

The review period is typically from July 1 through June 30 for each audit cycle. However, in August 2021 due to the COVID-19 pandemic, the MCOs were mandated to resume certain in-person Care Management activities. For this focus study, the compliance evaluation for Face to Face visits is for the period beginning August 15, 2021 through November 15, 2021. The study is currently underway. IPRO will provide the final report to DMAHS, and study findings will be presented in the next Annual Technical Report.

MLTSS 2022 Care Management and Continuity of Care Annual Assessment

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by the five MCOs, as evidence of compliance of the standards under review; interviews with key MCO staff (held via WebEx in January 2023), and post-audit evaluation of additional documentation provided by the MCOs were also reviewed.

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

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

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

The MLTSS Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements. The rating scale for *Met* and *Not Met* elements is presented in **Table 47**.

Table 47: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

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

There are 10 contractual provisions in the 2022 MLTSS Care Management category. **Table 48** presents the total compliance scores of 100% for all five MCOs.

Table 48: Compliance Scores by MCO for the 2022 MLTSS Care Management and Continuity of Care Annual Assessment Elements

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	10	10	0	**100%**
AGNJ	10	10	0	**100%**
HNJH	10	10	0	**100%**
UHCCP	10	10	0	**100%**
WCHP	10	10	0	**100%**

Table 49 presents the summary of findings for each element reviewed during the 2022 MLTSS Annual Assessment Care Management audit.

Table 49: Summary of Findings for MLTSS Care Management and Continuity of Care

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

No deficiencies were identified in the MLTSS 2022 Care Management and Continuity of Care Annual Assessment Review.

VIII. Focus Studies of Health Care Quality

2022 Prenatal and Postpartum Focus Study

Aim

In 2022, at the request of DMAHS, IPRO developed a clinical focus study on prenatal and postpartum care. This is a descriptive study whose aim is to identify sociodemographic disparities in the access and availability of prenatal and postpartum care among Medicaid beneficiaries in New Jersey as measured by the HEDIS PPC measure.

Methodology

The study population will be comprised of eligible Medicaid members with member-level administrative data for the Prenatal and Postpartum Care (PPC) HEDIS measure from all five MCOs from January 1, 2021, through December 31, 2021. This will include those who delivered a live birth and met continuous enrollment criteria for PPC for the 2021 measurement year.

Data Analysis

Member level administrative data for the Prenatal and Postpartum Care (PPC) HEDIS measure from all five MCOs will be analyzed separately as well as pooled. Analyses will be presented at the county and zip code level and will combine demographic information from the member level files received from the MCOs.

Findings

In 2023, the study is currently underway. IPRO will provide the final report to DMAHS and study findings will be presented in the next Annual Technical Report.

IX. Encounter Data Validation

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

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from Gainwell Technologies (formerly DXC Technology). IPRO loads the following data to IPRO's Statistical Analysis Software (SAS) data warehouse: member eligibility, demographic, TPL information, State-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation, and vision encounter data. Starting June 2020, IPRO also began receiving a monthly supplemental pharmacy file that includes additional data elements. During 2022, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts and to ensure the monthly file receipt.

X. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement (QI) made by the EQRO during the previous year's EQR." **Tables 50–54** display the MCOs' responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

ABHNJ Response to Previous EQR Recommendations

Table 50 displays ABHNJ's progress related to the *State of New Jersey DMAHS, Aetna Better Health of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of ABHNJ's response.

Table 50: ABHNJ Response to Previous EQR Recommendations

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ABHNJ should address the PIP validation elements that were determined to be not met or partially met.	The Plan continues to employ a full-time Clinical Lead to manage the PIPs and assure their implementation and monitoring as per the PIP proposal. The clinical lead will meet with the Director of Quality Management at least monthly to review the monitoring plan and PIP progress will be reported into the Quality Management committee on at least quarterly basis or as clinical input is needed. PIP workgroup meetings are held with key PIP stakeholders to discuss project progress, barriers and any new or modified interventions to address these barriers, as appropriate. Minutes and attendance are recorded for reference to assure follow-up items are resolved. Regular meetings are also held with the data support teams to ensure that extracted data is accurate and applicable to the relevant population. Data elements extracted from record review are validated by a second clinician through a review of a random sample selected from the total group of applicable reviewed records.	Addressed
The MCO should review each section and ensure accuracy for the Core Medicaid Improving Developmental Screening and Referral Rates to Early Intervention for Children PIP and revise and update multiple sections in order to be able to have a positive impact on the early intervention Services.	The Plan continues to employ a full-time Clinical Lead to manage the PIPs and assure their implementation and monitoring as per the PIP proposal. The clinical lead will meet with the Director of Quality Management at least monthly to review the monitoring plan and PIP progress will be reported into the Quality Management committee on at least quarterly basis or as clinical input is needed. Feedback received regarding the PIP submissions is also shared and discussed with the committee for their input. PIP workgroup meetings are held with key PIP stakeholders to discuss project progress, barriers and any new or modified interventions to address these barriers, as appropriate. Minutes and attendance are recorded for reference to assure follow-up items are resolved. Feedback received on the PIP submissions is also reviewed and discussed in the workgroups and adjustments will be made, as necessary. Breakout subgroups are also utilized to review and discuss specific interventions or data items associated with the PIP and any recommendations for changes are brought back to the larger workgroup for review and approval.	Addressed
The MCO should ensure emerging barriers and	The Plan continues to employ a full-time Clinical Lead to manage the PIPs and assure their implementation and monitoring as per the PIP	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
systemic challenges regarding the Core Medicaid MCO Adolescent Risk Behaviors and Depression Collaborative PIP outcomes are comprehensively discussed, evaluated, and factored into continuous performance improvement as the PIP enters the sustainability phase.	proposal. The clinical lead will meet with the Director of Quality Management at least monthly to review the monitoring plan and PIP progress will be reported into the Quality Management committee on at least quarterly basis and any clinical barriers or impediments will be presented for review and feedback during those meetings. PIP workgroup meetings are held separately for each PIP with key PIP stakeholders in attendance to discuss project progress, barriers and any new or modified interventions to address these barriers, as appropriate. Minutes and attendance are recorded for reference to assure follow-up items are resolved. Subgroup meetings are held as needed with applicable workgroup personnel to discuss issues that arise around specific interventions, data tracking or unexpected impediments to particular components of the PIP. Recommendations for adjustments resulting from these subgroup discussions are brought back to the larger workgroup for final review and approval.	
The MCO should review its approach with consideration to utilization of requisite data in accordance with the stated methodology, to ensure the efficacy of the MLTSS Reduction in ER and IP Utilization through Enhanced Chronic Disease Management PIP can be adequately evaluated.	The Plan continues to employ a full-time Clinical Lead to manage the PIPs and assure their implementation and monitoring as per the PIP proposal. The clinical lead will meet with the Director of Quality Management at least monthly to review the monitoring plan and PIP progress will be reported into the Quality Management committee on at least quarterly basis or as clinical input is needed. PIP workgroup meetings are held with key PIP stakeholders to discuss project progress, barriers and any new or modified interventions to address these barriers, as appropriate. Minutes and attendance are recorded for reference to assure follow-up items are resolved. Individual and smaller subgroup meetings with key stakeholders, including MLTSS clinical leadership, are held on both a regular and as needed basis to review workflow and documentation requirements. Regular meetings are also held with the data support teams to ensure that extracted data is accurate and applicable to the relevant population and to determine if efficiencies in data reporting can be implemented. Data elements extracted from record review are validated by a second clinician through a review of a random sample selected from the total group of applicable reviewed records.	Addressed
The MCO should ensure to provide the correct GeoAccess reports to show access compliance.	ABHNJ has made all needed corrections to assure each quarterly submission, the most updated contract requirements, templates, and reports are utilized.	Remains an opportunity for improvement.
The MCO should ensure to provide the correct GeoAccess reports to show access compliance for Adult PCPs, Pediatric PCP, Specialty Providers, Dental Providers and Hospitals.	ABHNJ has made all needed corrections to assure each quarterly submission, the most updated contract requirements, templates, and reports are utilized.	Remains an opportunity for improvement.
The MCO needs consistency in reporting to DMAHS and the EQRO	ABHNJ continues to monitor our network ensuring adequate access to care. Currently the plan has no deficiencies statewide for Adult Social Day Care providers.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
regarding MLTSS Adult Social Day Care providers.		
The MCO should continue to focus on improving appointment availability for obstetricians/gynecologists (OB/GYN), specialty and behavioral health providers, and after-hours availability statewide.	ABHNJ Identified a vendor that will expand provider outreach effort as well as resurvey all failed providers. 2022 HP will survey 100% of OB/GYN and Behavioral Health providers statewide this will include both Accessibility and After Hour studies. PR Office visit to confirm letter receipt and address any questions pertaining to state requirement. Vendor will re-survey each failed provider for compliance.	Addressed
The MCO should ensure to provide the correct GeoAccess reports to show access compliance for all categories.	ABHNJ has made all needed corrections to assure each quarterly submission, the most updated contract requirements, templates, and reports are utilized.	Remains an opportunity for improvement.
The MCO should ensure that Core Medicaid Provider grievance resolution letters are correct and sent to the members in a timely manner.	Data shows for the time period of July 1,2021 through June 15,2022 Core Medicaid Provider grievance resolution letters 92 out of 92 response letters were sent timely. We continue to monitor and review cases daily. If an issue is found, the primary owner is notified along with their supervisor. Corrections are made as needed. The review looks for case completeness for both internal and external requirements from data entry to letters and attachments. A summary of results is sent to identify trends for correction, including engagement with training for individual or whole team training or retraining.	Addressed
The MCO should ensure that UM Core Medicaid provider and member notifications are done in a timely manner.	There is a specific team designated to writing letters. Daily, and throughout the day, there is communication between that team and the reviewing teams to ensure letters are sent out timely. Letters are audited by that team and/or CCR and PA Management. Education is provided to all teams regarding contractual TAT for Notification on an ongoing basis.	Addressed
The MCO should ensure that MLTSS provider grievances resolution letters are completed and included in files.	Data shows for the time period of July 1,2021 through June 15,2022 MLTSS provider grievances resolution letters are complete and attached to the file for 7 out of 7 files. We continue to monitor and review cases daily. If an issue is found, the primary owner is notified along with their supervisor. Corrections are made as needed. The review looks for case completeness for both internal and external requirements from data entry to letters and attachments. A summary of results is sent to identify trends for correction, including engagement with training for individual or whole team training or retraining.	Addressed
The MCO should ensure that MLTSS provider appeals resolution letters are completed with a medical decision and in a final format before sending to provider	We continue to monitor and review cases daily. If an issue is found, the primary owner is notified along with their supervisor. Corrections are made as needed. The review looks for case completeness for both internal and external requirements from data entry to letters and attachments. A summary of results is sent to identify trends for correction, including engagement with training for individual or whole team training or retraining.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	ABHNJ submitted a 2021 HEDIS Workplan to the State for review which included a barrier analysis and interventions to address each measure that fell below the NCQA 50th percentile. An interdisciplinary HEDIS workgroup continues to meet monthly to monitor rate improvement and update the workplan on a quarterly basis. An increase in member outreach included, telephonic calls, IVR and SMS campaigns. ABHNJ continues to work with targeted provider groups to improve member outcomes by Quality Management and Population Health Specialists by frequently meeting with providers, reviewing medical records, claims data, and member rosters to identify opportunities for improvement specific to each practice. An increase focus was placed on obtaining supplemental data and conducting year-round abstraction.	Addressed
The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO PM Validation.	ABHNJ has reviewed and updated its Population Definition Grid to ensure reporting accuracy related to subpopulations, including but not limited to MLTSS. An assigned Project Manager is responsible for monitoring completeness and timeliness of report submission. A tracking system details performance measure requests, due dates, and responsible parties for completion. At each point of data or reporting completion, at least two staff members review the results for completeness and accuracy. This includes checking incoming data files for accuracy, data prepared for the HEDIS vendor, checks for completeness of data load to HEDIS vendor software, accuracy of HEDIS rates calculated by the vendor software, and accuracy of NJ-specific rates and member level files prior to submission to IPRO.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	ABHNJ submitted a 2021 CAHPS Workplan to the State for review which included a barrier analysis and interventions to address each composite and measure that fell below the NCQA 50th percentile. An interdisciplinary CAHPS workgroup meets monthly to discuss the status of each intervention. New interventions included the implementation of a Pre-CAHPS (mock) survey via IVR to identify actionable results related to provider groups and/or geographical areas. In addition, the Plan implemented call listening sessions to listen to randomly selected to identify opportunities for improvement.	Addressed
ABHNJ should address the deficiencies noted in the Core Medicaid -2021 CM Review in the following areas • GP – Identification, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	Aetna Better Health New Jersey (ABHNJ) recognizes that member identification is an important first step for care management. GP (General Population) identification begins with the Initial Health Screen (IHS). ABHNJ is actively working on improving the IHS completion rate. In addition to hiring and training additional staff for the Engagement Hub team during Q3 and Q4 2021, Aetna implemented a Rapid Response team in November 2021 which provides ABHNJ with resources that “float” to provide support to outreach activities as needed. This team has assisted with both member outreach for care management and post discharge follow up calls. ABHNJ has the Eliza Integrated Voice Recognition System in place who contacts members at the time of enrollment for the IHS. The Engagement Hub Supervisor has ongoing meeting sessions with the Eliza engineers to review the data, methodology, and algorithms for reporting. This ensures accurate and timely data collection. All	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	members that do not respond to the Eliza calls are sent a letter with paper copy of the IHS and a self-addressed stamped envelope. Processing returned mail in the office during the pandemic was a challenge, however during Q1 2021 two staff were assigned to process mail and complete the data entry. Beginning Q2 2022 staffing has been reallocated to meet the data entry needs. ABHNJ is currently working within the CVS system to join the offsite processing of returned mail which would feed the IHS results into the member's file in the Dynamo documentation system. The offsite processing efficiency would replace the manual process currently in place. Additionally, ABHNJ is in the process of setting up a Nanosite which would text members who have not responded to the above IHS outreach attempts. The Care Management Warming/Unable to Reach (UTR) Project is in progress, this would allow members to call the ABHNJ main phone number and choose options to route directly to care management, thus eliminating the Member Services "middleman". Integrated Care Management (ICM) managers and the Engagement Hub leadership meet weekly to review the IHS and Outreach process, discuss timeliness and address any barriers. An ABHNJ triage nurse reviews all completed IHS questionnaires to identify candidates for care management. ABHNJ conducts a Comprehensive Needs Assessment (CNA) within 30 days for new Enrollees following this IHS evaluation and when a member is identified as having potential needs. Aggressive outreach is performed to reach members for the CNA. ICM managers have re-educated the team (December 2021 completed and continues) regarding the CNA timeframes, monthly reminders are in place, and staff received a copy of the Care Management Workbook. The team has been trained to identify the CNA due date. ICM care managers complete the CNA upon their initial contact with the member during the initial introduction. Based on the CNA, the Care Manager will assign a care level, develop a Care Plan, and facilitate and coordinate the care of each member according to his/her needs or circumstances. With input from the member and/or caregiver and Primary Care Physician (PCP), the Care Manager must jointly create a Care Plan with prioritized short and long-term care management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the member and/or caregiver. Understanding that member's care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the current needs. Care plan requirements are re-educated to staff routinely; extensive training including timeframes, development, and updating of care plans was provided on 10/7/2021 and 6/21/2022 during the monthly team meetings. All staff received training on cultural sensitivity during 2021 and again during August 2022. A new platform, Socially Determined, is in progress to include member level detail of Social	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Determinants of Health (SDoH) risks. Staff completed training during Q2 2022. Care plan goals and actions are in place and used to track issues over time with an emphasis on improving health outcomes, preventative services completion, and maintaining functional abilities. ICM care managers refer members with functional limitations to the ABHNJ Assessor Team who provides options counseling and completes the Personal Care Assistant (PCA) Nursing Assessment Tool for PCA/PPP (Personal Preference Program) services. The Assessor and the ICM CM collaborate to ensure that services are in place. Assessor documentation is available in the member's file journal which the ICM CM reviews. ICM care managers assure that members are educated on the importance of preventative services and health maintenance. Additionally, staff have been re-educated and provided access to New Jersey Immunization Information System (NJIIS) to obtain verified immunization records as appropriate when not received from PCP. Staff monitor claims and collaborate with PCPs regarding timely Early and Periodic Screening Diagnostic and Treatment (EPSDT) exams for ages under 21 years. Staff have been provided access to the Liberty Dental portal to verify dental exam information and assist the member to complete any gap in care. ICM staff have access to the March Vision portal to obtain verified eye exam and lab data. To obtain verified Lead test results for children aged 6 and under, ICM care managers monitor claims, follow up with PCPs, and are provided a Lead Report Weekly which includes test results. ICM staff complete a preventative documentation template with the CNA to ensure that EPSDT, dental, vision, and lead have been completed as appropriate. In the Dynamo system any Healthcare Effectiveness Data and Information Set (HEDIS) gap in care generates an automatic alert in the member's file which is then addressed by the care manager. During 2021 COVID continued to impact case management operations, impacting Face to Face member interactions and staffing. During 2022 we have filled all positions and completed the new staff onboarding. Care managers have manageable caseloads allowing the ability to verify preventative services data. ABHNJ has reports in place and projects beginning to ensure timeliness. A CM ICM Dashboard went live in December 2020 which shows timeliness in real time that drills down to the member-specific demographics by care manager. This dashboard includes CNA, Care Plan review, and Interval Assessment timeliness data. During 2022 it was implemented that staff are required to review the dashboard daily. The Dynamo Monitoring Report, which identifies member who still need outreach, began 1/4/0222. To ensure timeliness of the care plan, ICM managers review the monthly NJ ICM Care Plan Report which was developed and implemented on 12/18/2020. This report provides data including	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	dates, agreement, and status of care plan in addition to CNA information. CVS is currently implementing a CM Process Measuring Project in which identified staff will have new software added to collect baseline measurements of activities to determine how we can gain efficiencies for the future. Mangers and staff receive the Inpatient (IP) Census Report daily to monitor the admission status of members (this process was confirmed on 9/3/2021). The ABHNJ ICM team will ensure adequate and appropriate discharge planning including coordination of services when members are hospitalized. The managers have re-educated staff to reach out to member/family and hospital discharge planners to coordinate discharge activities. A Readmission Avoidance Program (RAP) was implemented on 9/10/2021 and updated on 6/24/2022. CM staff receive a task for their members for each inpatient authorization and institute calls while the member is still in the hospital. The Engagement Team monitors the system's IP Alert queue and contacts all members not assigned to a care manager for the post discharge questionnaire and to offer care management. Any member with a RAP score of 50+% is assigned to a nurse for immediate outreach. On 9/14/2021 the ICM managers reviewed desktops and job aids during the staff meeting. Effective Q3 2021 the ICM manager or designee has attended Utilization Management (UM) Inpatient Rounds daily and assists with transition and coordination of care. ICM has a nurse dedicated to the transition of care process. Care managers have been re-educated to document all contacts and linkages to medical and other services in the member's file. The care manager will document all resources and referrals provided to the member in the Community Resources/Referral event in the member's file. Since Q2 2022 we have implemented the process that the care manager sets a task for 2 weeks to follow up and close the loop on these events. The Aetna Program Integrity team conducts monthly file audits for compliance of this factor. This ensures that the care manager coordinates and follows through regarding all needed care/services and actively links members to providers and services. Additionally, ICM staff have been retrained (May 2021, September 2021, 4/18/2022 and 8/12/2022) to use the available platforms such as FindHelp (formerly Aunt Bertha) to identify and coordinate referrals for community-based resources. ABHNJ has received state authorization (October 2021) for FindHelp to receive ICM referrals and communicate with members to close gaps. ABHNJ has a Behavioral Health Administrator and a Peer Support Specialist (PSS) who collaborate with ICM regarding behavioral health referrals and substance abuse issues. ABHNJ formed a partnership with HealPros (Q3 2022) who outreaches members diagnosed with Diabetes who have a gap in care to complete in-home eye exams and HgA1c (Hemoglobin A1c) tests. Beginning in Q4 2022 ABHNJ will partner with PYX Health to provide	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	telephonic care to those who are lonely, depressed or have an SDoH issue; care managers have received training Q3 2022. The Healthy Home Visit Program began Q1 2022 which provides members a comprehensive evaluation with a mobile practitioner during a home visit, this evaluation is then shared with member's PCP. The Integrated Care for Kids (InCK) program was implemented 1/1/2022 which focuses on the well-being of children and families who receive Medicaid in Monmouth and Ocean Counties. Staff received training and a copy of the newly documented NJ InCK job aid. The Program Integrity Audit Team conducts monthly file audits for adherence to desktops and job aids. Managers work with the audit team to review records, find examples of best practices, and assist staff with continued training. The manager and each staff receive and review each completed audit for re-education as needed. Audit results are presented to ICM leadership monthly and to senior leadership quarterly. Overall audit scores have been trending at 90% or above.	
ABHNJ should address the deficiencies noted in the Core Medicaid -2021 CM Review in the following areas: • DDD – Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	ABHNJ recognizes that reaching the member is the first step in assisting the DDD population with coordination of services. Thus, in addition to increasing the ABHNJ team during Q3 and Q4 2021, the Engagement Hub team implemented a Rapid Response team in November 2021 which provides ABHNJ with resources to "float" to provide support to outreach activities as needed. This team has assisted with both member outreach for care management and post discharge follow up calls. This process allows seasoned staff to complete outreach to the Special Needs populations upon enrollment to ensure that aggressive outreach is completed. The Care Management Warming/UTR Project is in progress, this would allow members to call the ABHNJ main phone number and choose options to route directly to care management, thus eliminating the Member Services "middleman". ICM managers and the Engagement Hub leadership meet weekly to review the Outreach process, discuss timeliness and address any barriers. ABHNJ conducts a Comprehensive Needs Assessment (CNA) within 45 days for new Enrollees. Soft skills training has been completed with staff to reinforce motivational interviewing skills to engage members for the CNA (completed 6/21/2022). Aggressive outreach is performed to reach members for the CNA. ICM managers have re-educated the team (December 2021 implemented and continues) regarding the CNA timeframes, monthly reminders are in place, and staff received a copy of the Care Management Workbook. The team has been trained to identify the CNA due date. ICM care managers complete the CNA upon their initial contact with the member during the initial introduction. Based on the CNA, the Care Manager will assign a care level, develop a Care Plan, and facilitate and coordinate the care of each member according to his/her needs or circumstances. With input from the member and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measurable quality	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the member and/or caregiver. Understanding that member's care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the current needs. Care plan requirements are re-educated to staff routinely; extensive training including timeframes, development, and updating of care plans was provided on 10/7/2021 and 6/21/2022 during the monthly team meetings. All staff received training on cultural sensitivity during 2021 and again during August 2022. A new platform, Socially Determined, is in progress to include member level detail of Social Determinants of Health (SDoH) risks. Staff completed training during Q2 2022. Care plan goals and actions are in place and used to track issues over time with an emphasis on improving health outcomes, preventative services completion, and maintaining function abilities. ICM care managers refer members with functional limitations to the ABHNJ Assessor Team who provides options counseling and completes the PCA Nursing Assessment Tool for PCA/PPP services. The Assessor and the ICM CM collaborate to ensure that services are in place. Assessor documentation is available in the member's file journal which the ICM CM reviews. ICM care managers assure that members are educated on the importance of preventative services. Additionally, staff have been re-educated and provided access to New Jersey Immunization Information System (NJIIS) to obtain verified immunization records when not received from PCP or via the weekly Special Needs Immunization Report. Staff monitor claims and collaborate with PCPs regarding timely EPSDT exams for ages under 21 years. Staff have been provided access to the Liberty Dental portal to verify dental exam information. Additionally, ICM staff work with the Liberty Dental care management team to ensure that DDD members have their dental needs met. ICM receives a monthly report from Liberty Dental for DDD members with non-utilization. The ICM care manager then contacts the member to assist with setting an appointment or providing referrals as needed. ICM staff have access to the March Vision portal to obtain verified eye exam and lab data. To obtain verified Lead test results for children aged 6 and under, ICM care managers monitor claims, follow up with PCPs, and are provided a Lead Report Weekly which includes test results. ICM staff complete a preventative documentation template with the CNA and updated annually to ensure that EPSDT, dental, vision, and lead have been completed as appropriate. In the Dynamo system any HEDIS gap in care generates an automatic alert in the member's file which is then addressed by the care manager. During 2021 the ICM department had challenges related to COVID and staffing shortages. During 2022 we have filled all positions and completed the new staff onboarding. Care managers have manageable caseloads allowing the ability to verify preventative services data.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	The ABHNJ ICM team will ensure adequate and appropriate discharge planning including coordination of services when members are hospitalized. The managers have re-educated staff to reach out to member/family and hospital discharge planners to coordinate discharge activities. A Readmission Avoidance Program (RAP) was implemented on 9/10/2021 and updated on 6/24/2022. CM staff receive a task for their members for each inpatient authorization and institute calls while the member is still in the hospital. On 9/14/2021 the ICM managers reviewed desktops and job aids during the staff meeting. Effective Q3 2021 the ICM manager or designee has attended UM Inpatient Rounds daily and assists with transition and coordination of care. ICM has a nurse dedicated to the transition of care process. ABHNJ has reports in place and projects beginning to ensure timeliness. A CM ICM Dashboard went live in December 2020 which shows timeliness in real time that drills down to the member-specific demographics by care manager. This dashboard includes CNA, Care Plan review, and Interval Assessment timeliness data. During 2022 it was implemented that staff are required to review the dashboard daily. The Dynamo Monitoring Report, which identifies member who still need outreach, began 1/4/0222. To ensure timeliness of the care plan, ICM managers review the monthly NJ ICM Care Plan Report which was developed and implemented on 12/18/2020. This report provides data including dates, agreement, and status of care plan in addition to CNA information. CVS is currently implementing a CM Process Measuring Project in which identified staff will have new software added to collect baseline measurements of activities to determine how we can gain efficiencies for the future. Mangers and staff receive the IP Census Report daily to monitor the admission status of members (this process was confirmed on 9/3/2021). Care managers have been re-educated to document all contacts and linkages to medical and other services in the member's file. The care manager will document all resources and referrals provided to the member in the Community Resources/Referral event in the member's file. Since Q2 2022 we have implemented the process that the care manager sets a task for 2 weeks to follow up and close the loop on these events. The Aetna Program Integrity team conducts monthly file audits for compliance of this factor. This ensures that the care manager coordinates and follows through regarding all needed care/services and actively links members to providers and services. Additionally, ICM staff have been retrained (May 2021, September 2021, 4/18/2022 and 8/12/2022) to use the available platforms such as FindHelp (formerly Aunt Bertha) to identify and coordinate referrals for community-based resources. ABHNJ has received state authorization (October 2021) for FindHelp to receive ICM referrals and communicate with members to close gaps. ABHNJ has a Behavioral Health Administrator and a Peer Support Specialist (PSS) who collaborate with ICM regarding	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	behavioral health referrals and substance abuse issues. ABHNJ formed a partnership with HealPros (Q3 2022) who outreaches members diagnosed with Diabetes who have a gap in care to complete in-home eye exams and HgA1c tests. Beginning in Q4 2022 ABHNJ will partner with PYX Health to provide telephonic care to those who are lonely, depressed or have an SDoH issue; care managers have received training Q3 2022. The Healthy Home Visit Program began Q1 2022 which provides members a comprehensive evaluation with a mobile practitioner during a home visit, this evaluation is then shared with member's PCP. The Integrated Care for Kids (InCK) program was implemented 1/1/2022 which focuses on the well-being of children and families who receive Medicaid in Monmouth and Ocean Counties. Staff received training and a copy of the newly documented NJ InCK job aid. The Program Integrity Audit Team conducts monthly file audits for adherence to desktops and job aids. Managers work with the audit team to review records, find examples of best practices, and assist staff with continued training. The manager and each staff receive and review each completed audit for re-education as needed. Audit results are presented to ICM leadership monthly and to senior leadership quarterly. Overall audit scores have been trending at 90% or above.	
ABHNJ should address the deficiencies noted in the Core Medicaid -2021 CM Review in the following areas: • DCP&P – Preventive Services, and all CM element specific deficiencies noted in the review.	ABHNJ recognizes that reaching the member is the first step in assisting the DDD population with coordination of services. Thus, in addition to increasing the ABHNJ team during Q3 and Q4 2021, the Engagement Hub team implemented a Rapid Response team in November 2021 which provides ABHNJ with resources to "float" to provide support to outreach activities as needed. This team has assisted with both member outreach for care management and post discharge follow up calls. This process allows seasoned staff to complete outreach to the Special Needs populations upon enrollment to ensure that aggressive outreach is completed. The Care Management Warming/UTR Project is in progress, this would allow members to call the ABHNJ main phone number and choose options to route directly to care management, thus eliminating the Member Services "middleman". ICM managers and the Engagement Hub leadership meet weekly to review the Outreach process, discuss timeliness and address any barriers. ABHNJ conducts a Comprehensive Needs Assessment (CNA) within 45 days for new Enrollees. Aggressive outreach is performed to reach DCP&P members for the CNA. Outreach includes calls to Resource Parents, DCP&P nurse and case worker, and the PCP. ICM managers have re-educated the team (December 2021 implemented and continues) regarding the CNA timeframes, monthly reminders are in place, and staff received a copy of the Care Management Workbook. The team has been trained to identify the CNA due date. ICM care managers complete the CNA upon their initial contact with the member during the initial introduction.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Based on the CNA, the Care Manager will assign a care level, develop a Care Plan, and facilitate and coordinate the care of each member according to his/her needs or circumstances. With input from the member and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term care management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the member and/or caregiver. Understanding that member's care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the current needs. Care plan requirements are re-educated to staff routinely; extensive training including timeframes, development, and updating of care plans was provided on 10/7/2021 and 6/21/2022 during the monthly team meetings. All staff received training on cultural sensitivity during 2021 and again during August 2022. A new platform, Socially Determined, is in progress to include member level detail of Social Determinants of Health (SDoH) risks. Staff completed training during Q2 2022. Care plan goals and actions are in place and used to track issues over time with an emphasis on improving health outcomes, preventative services completion, and maintaining function abilities. ICM care managers assure that members are educated on the importance of these services. Additionally, staff have been re-educated and provided access to New Jersey Immunization Information System (NJIIS) to obtain verified immunization records when not received from PCP or via the weekly Special Needs Immunization Report. Staff monitor claims and collaborate with PCPs regarding timely EPSDT exams. Staff have been provided access to the Liberty Dental portal to verify dental exam information; staff assist with setting an appointment or providing referrals as needed. ICM staff have access to the March Vision portal to obtain verified eye exam and lab data. To obtain verified Lead test results for members aged 6 and under, ICM care managers monitor claims, follow up with PCPs, and are provided a Lead Report Weekly which includes test results. ICM staff complete a preventative documentation template with the CNA and updated annually to ensure that EPSDT, dental, vision, and lead have been completed as appropriate. In the Dynamo system any HEDIS gap in care generates an automatic alert in the member's file which is then addressed by the care manager. During 2021 the ICM department had challenges related to COVID and staffing shortages. During 2022 we have filled all positions and completed the new staff onboarding. Care managers have manageable caseloads allowing the ability to verify preventative services data. The ABHNJ ICM team will ensure adequate and appropriate discharge planning including coordination of services when members are hospitalized. The managers have re-educated staff to	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	reach out to Resource Parent, DCP&P, and hospital discharge planners to coordinate discharge activities. A Readmission Avoidance Program (RAP) was implemented on 9/10/2021 and updated on 6/24/2022. CM staff receive a task for their members for each inpatient authorization and institute calls while the member is still in the hospital. On 9/14/2021 the ICM managers reviewed desktops and job aids during the staff meeting. Effective Q3 2021 the ICM manager or designee has attended UM Inpatient Rounds daily and assists with transition and coordination of care. ICM has a nurse dedicated to the transition of care process. ABHNJ has reports in place and projects beginning to ensure timeliness. A CM ICM Dashboard went live in December 2020 which shows timeliness in real time that drills down to the member-specific demographics by care manager. This dashboard includes CNA, Care Plan review, and Interval Assessment timeliness data. During 2022 it was implemented that staff are required to review the dashboard daily. The Dynamo Monitoring Report, which identifies member who still need outreach, began 1/4/0222. To ensure timeliness of the care plan, ICM managers review the monthly NJ ICM Care Plan Report which was developed and implemented on 12/18/2020. This report provides data including dates, agreement, and status of care plan in addition to CNA information. CVS is currently implementing a CM Process Measuring Project in which identified staff will have new software added to collect baseline measurements of activities to determine how we can gain efficiencies for the future. Mangers and staff receive the IP Census Report daily to monitor the admission status of members (this process was confirmed on 9/3/2021). Care managers have been re-educated to document all contacts and linkages to medical and other services in the member's file. The care manager will document all resources and referrals provided to the member in the Community Resources/Referral event in the member's file. Since Q2 2022 we have implemented the process that the care manager sets a task for 2 weeks to follow up and close the loop on these events. The Aetna Program Integrity team conducts monthly file audits for compliance of this factor. This ensures that the care manager coordinates and follows through regarding all needed care/services and actively links members to providers and services. Additionally, ICM staff have been retrained (May 2021, September 2021, 4/18/2022 and 8/12/2022) to use the available platforms such as FindHelp (formerly Aunt Bertha) to identify and coordinate referrals for community-based resources. ABHNJ has received state authorization (October 2021) for FindHelp to receive ICM referrals and communicate with members to close gaps. ABHNJ has a Behavioral Health Administrator and a Peer Support Specialist (PSS) who collaborate with ICM regarding behavioral health referrals and substance abuse issues.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	The Program Integrity Audit Team conducts monthly file audits for adherence to desktops and job aids. Managers work with the audit team to review records, find examples of best practices and assist staff with continued training. The manager and each staff receive and review each completed audit for re-education as needed. Audit results are presented to ICM leadership monthly and to senior leadership quarterly. Overall audit scores have been trending at 90% or above.	
ABHNJ should address the deficiencies noted in the MLTSS – HCBS 2021 CM Review for elements that scored below 86%.	IPRO offered recommendation improvement for the elements of Member Outreach regarding Screen for Community Services timeliness. It was recommended that Aetna ensure the Care Manager contacts the Member telephonically to conduct a Screening for the Community Services Assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification. ABHNJ took immediate actions by sending assessors a case collaboration task upon receipt of MLTSS Referrals in the Care Management System (Dynamo). The assessor is to prioritize the visit by scheduling the face-to-face within 2 weeks of the referral. The supervisor for the assessor team monitors the task list of each assessor in the Care Management System (Dynamo) weekly to ensure all assessors are current. The task list is to remain current and no more than 1-day behind without proper documentation in the member file. ABHNJ's detailed actions and system changes included multiple actions: the SCS is conducted in the member's electronic health record by the Integrated Care Manager (ICM Plan A). If the member appears to meet the criteria for MLTSS, the ICM care manager sends a referral to a shared mailbox for the assessor team. The assessor supervisor monitors the shared mailbox daily, and upon receipt of the referral, a case collaboration task is sent to an assessor. The assessor conducts a review of the member's electronic health record to ensure the screener is completed. If the screener is not completed, the assessor will conduct the screener over the phone to determine if member may meet MLTSS eligibility within the timeframes provided. The assessor will then create a task in the member's electronic health record and schedule the visit within 2 weeks. IPRO offered recommendations for improvement for elements of the Telephonic Monitoring (formerly Face-to-face) Visits category regarding options counseling. It was recommended that Aetna ensure option counseling is provided to all MLTSS Members, including discussing and offering Participant Direction as applicable during Options Counseling. Aetna was recommended to ensure that the Participant Direction Application packet is completed and submitted within thirty (30) business days of the Member's request to self-direct. Aetna also recommended to ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold should be documented as a numeric percentage. ABHNJ took immediate actions by reviewing with the team the importance of obtaining a signature on the Interim Plan of	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Care to document proof that options counseling has occurred. A PDF version of the Interim Plan of Care was added to the initial and annual workflows to be completed when the visit occurs telephonically so that options counseling can still be documented sufficiently, without the use of the NJCA/IPOC transmitted to OCCO. This aims to improve care manager documentation surrounding the offering of options counseling to the member, including the option to utilize PPP. PPL presented at an MLTSS Team Meeting 2/10/22 to provide an overview of the self-direction program and the PPL portal. Care Managers will have improved visibility to review the status of the PPP Application and be able to address timeliness issues in real time. MLTSS Leadership reviewed the importance of completing a cost neutrality analysis during initial visits, annuals visits, and significant changes at Team Meetings. ABHNJ's detailed actions included workflow enhancements and ensuring CES was properly documented in a numeric percentage during the monthly CM Audits, as this is a metric audited monthly. ABHNJ leadership has updated the CM file Audit Tool to include "CES must be documented as percentage". IPRO offered recommendations for improvement for elements of the Initial Plan of Care (Including Back-up Plans) category. It was recommended that Aetna ensure that the Plan of Care reflects a member-centric approach, and the Member/Member Representative is present and involved in the development and modification of agreed upon goals and is given the opportunity to express their needs or preferences, and their needs or preferences are acknowledged and addressed in the Plan of Care. Aetna was recommended to ensure the Care Manager completes an Annual Risk Assessments for MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member. Aetna also recommended to ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Member's understand their Rights and Responsibilities ABHNJ took immediate action by conducting a re-training session for the entire team at a team meeting on 2/15/2022. The meeting focused on reviewing contractual timeliness for initial plan of care development. An enhanced report from the MLTSS dashboard was created and implemented to provide leadership with daily numbers of cases that are overdue and interval visits that are approaching due. This report includes the members that are due for their initial assessment and plan of care. The report enabled Supervisors to view month-long trends in productivity utilizing the morning traffic report. If a CM fails to show progress and remains untimely with 10+ cases that need a plan of care within the first 45 days of enrollment with MLTSS, supervisors will discuss a plan of remediation for that case manager.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	IPRO offered recommendations for improvement for elements of the Ongoing Care Management category. It was recommended that Aetna ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period: ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for members in CARS. Aetna was recommended to ensure that the Member's Back-up Plan is reviewed at least quarterly for Member's residing in the Community. Aetna recommended ensuring that the Care Manager completes a telephonic visit within 10 business days of the Member's discharge from an institutional facility to an HCBS setting. Recommended that Aetna ensure that Plans of Care are reviewed, and/or amended and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the member's needs or condition as well as when the Member's Initial Plan of Care requires revision, the Plan of Care is reviewed and/or revised, the Care Manager should confirm the Member's agreement, signature/verbally acknowledgement, and a copy of the Plan of Care should be provided to the Member. Aetna was recommended to ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. ABHNJ took immediate action by reviewing timeliness requirements at team meeting 2/15/22 and ongoing, revising a job aide on significant change in conditions that specifics contractual timeliness and proper documentation in the member file and plan of care. An additional step to the interval and annual visit workflows was added to direct CMs to add to their task list within the Care Management system to notate if any documents are missing signatures and task self to obtain signatures at the subsequent face-to-face visit. Timeliness regarding initial care plans, agreement, and acknowledgement of plans of care and updating documentation based on members' significant change in condition will continuously be reiterated to staff at monthly team meetings and supervisor one on one meetings. Additionally, with Aetna's new Readmission Avoidance Program (RAP), our Dynamo Case Trakker system has been updated to auto-task care managers from any members' charts that have an inpatient authorization initiated by ABHNJ's Utilization Management Department. LTSS Staff were educated on how to find the active Inpatient Alert tasks and how to address them in a timely manner. Advancements in the documentation system allow the case managers to provide quicker response to inpatient stays and therefore schedule post discharge visits timelier. An enhanced report from the MLTSS dashboard was created and implemented to provide leadership with daily numbers of cases that are overdue and interval visits that are approaching due. This report includes the members that are due for their initial assessment and plan of care. The report enabled Supervisors to view month-long trends in productivity utilizing the morning traffic report. If a CM fails to show progress and remains untimely with 10+ cases that need a plan of care within the first 45 days of enrollment	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	with MLTSS, supervisors will discuss a plan of remediation for that case manager. IPRO offered recommendations for improvement for Performance Measures #8: Aetna should ensure that the Initial Plans of Care are developed within 45 days of enrollment into the MLTSS program. ABHNJ took immediate action by having the MLTSS support team continue to schedule initial visits for the MLTSS CMs to ensure the visit and plan of care is completed within 45 days of enrollment. Case Managers are not permitted to reschedule the initial Plan of Care visits without approval from their supervisor, this ensures accountability for the visit being held in the first 45 days of enrollment. MLTSS leadership held a training session that included review of contractual timeliness regarding initial care plans to be completed and signed within 45 days of enrollment. Effective as of 2/2/2022, the MLTSS Project Manager created and implemented a daily report that demonstrated the number of upcoming visits per case manager. The MLTSS supervisors utilize this data to reinforce timeliness requirements and monitor progress about care management staff. In addition to monitoring the MLTSS dashboard weekly, the MLTSS CMs must maintain their task list up to date to ensure timeliness is met with each face-to-face visit. The task list is in our Case Tracker Dynamo system. During the scheduled one-to-one's, the CMs must share their task list with their supervisor and provide a plan for outdated face-to-face visit task. IPRO offered recommendations for improvement for Performance Measures #9a: Aetna should ensure that the Member's Plan of Care is amended based on change of member condition, and the Plan of Care is reviewed, signed/verbally acknowledged, and dated by the Member/Member Representative. To address this recommendation, ABH received a job aide titled Significant Change in Condition with the full team between 2/15/22- 2/17/22. The job aide was updated and revised to provide further details regarding contractual timeliness, sufficient documentation, and requirement to review and amend the plan of care when a significant change occurs. Aetna ensures the above occurs via the monthly audits conducted by the Aetna Audit Team. The audit tool contains questions that specifically measure charts that demonstrate significant changes, and if appropriate documentation was completed. Monthly, the Case Management team receives audits. Each individual case manager who averages below 90% receives an individual remediation. Sustained poor audit results result in formal Performance Counseling. MLTSS training agenda for new hires includes person centered training. IPRO offered recommendations for improvement for Performance Measures #11: Aetna should ensure that the Plan of Care reflects "Person-Centered Principles", and the Member/Member Representative is present and involved in the Plan of Care development. MLTSS Case Management staff was reeducated on person centered principles during a training on 2/15/22. Aetna has	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	been working with executive leadership. Aetna met with Boston University regarding a Person-Centered Training Certificate on 4/27/22, but this did not need the needs of the health plan. Aetna continues to work with CVS Health Aetna Medicaid Leadership to seek alternative options. Monthly, the Case Management team receives audits. Each individual case manager who averages below 90% receives an individual remediation. Sustained poor audit results result in formal Performance Counseling. MLTSS training agenda for new hires includes person centered training.	
ABHNJ should address the deficiencies noted in the MLTSS – NF 2021 CM Review for elements that scored below 86%.	IPRO offered recommendations for improvement for audit elements for Aetna's MLTSS Care Managers to ensure the Member's Plan of Care is reviewed, revised if applicable, and confirm the agreement/disagreement statement is reviewed and signed by the Member/POA. It is recommended that the MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. Aetna is to ensure the MLTSS Care Managers discuss payment liability and review the Member's placement and services timely. ABHNJ leadership took immediate action by providing training on timely visits as per the contract, and the requirement to review and verify member's placement and services during those visits. Each month, MLTSS leadership meet with the Aetna National Audit/Float Team to review results of monthly file audits. MLTSS implements and will continue to implement interventions for staff who score below 90%. MLTSS supervisors will monitor the MLTSS Dashboard weekly for timeliness. MLTSS leadership continues to utilize a NF IDT report that identifies how many days it has been since the last IDT event was completed and documented in Dynamo. The report is then processed to task CMs for any upcoming or overdue IDTs so that every member can have an annual Interdisciplinary Care Team Event, as per contractual requirements. Monthly, the Case Management team receives audits: this includes metrics on education of cost share. Case managers who fail to educate members on cost share as per the audit results receive a 1:1 discussion from their supervisor to review cost share and the importance of explaining it to the member. Sustained failure to educate members on cost share will result in formal Performance Counseling. IPRO offered recommendations for improvement in MLTSS Performance Measures for the MLTSS Care Managers to certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary. Aetna provided retraining to the team on 12/2/21 regarding visit timeliness and the importance of this metric. An enhanced report from the MLTSS dashboard was created and implemented to provide leadership with daily numbers of cases that are overdue and interval visits that are approaching due. This report includes the members that are due for their initial assessment and plan of care. The report enabled Supervisors to view month-long trends in productivity utilizing the morning traffic report. If a CM fails to show progress and remains	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	untimely with 10+ cases that need a plan of care within the first 45 days of enrollment with MLTSS, supervisors will discuss a plan of remediation for that case manager. Monthly, the Case Management team receives audits: this includes metrics on visit timeliness. Each individual case manager who averages below 90% receives an individual remediation. Sustained poor audit results result in formal Performance Counseling.	

[1] **Addressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2023.

AGNJ Response to Previous EQR Recommendations

Table 51 displays AGNJ's progress related to the *State of New Jersey DMAHS, Amerigroup New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of AGNJ's response.

Table 51: AGNJ Response to Previous EQR Recommendations

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
AGNJ should address the PIP validation elements that were determined to be not met or partially met.	Amerigroup continues PIP-specific workgroups with dedicated staff leads within the operational teams to work with the QM PIP lead and a dedicated physician to support the analysis and evaluation of PIP activities. A team of data analysts is utilized in order to expand data collection, analysis, and monitoring to ensure a more comprehensive review. A quarterly data review and a deep-dive analysis of applicable measures is conducted by the PIP specific workgroup, to assess current PIP data reported and evaluate if additional analytic reporting options should be developed to further support PIP intervention measurement and tracking. The Plan maintains a PIP monitoring work plan to track intervention and data/reporting needs to ensure accountability for intervention oversight and data deliverables. In 3Q2021, an additional physician was assigned to the MLTSS Medicaid PIPs to assist with PIP oversight and alignment with PIP objectives and goals. In 4Q2021, the quarterly deep dive analysis was expanded to include PIP intervention demonstration assessment to monitor data analysis and improvement in PIP intervention performance. Amerigroup will continue to monitor its PIP processes related to opportunities for improvement. The QM PIP lead continues to work with all involved operational areas and reporting departments to ensure accurate data collection, review and analysis, and timely intervention implementation.	Addressed
The Plan should focus on intervention details, monitoring and evaluating at close intervals to ensure that implementation	Amerigroup continues PIP-specific workgroups with dedicated staff leads within the operational teams to work with the QM PIP lead and a dedicated physician, to support the analysis and evaluation of PIP activities. A team of data analysts is utilized in order to expand data collection, analysis, and monitoring to ensure a more comprehensive review. A quarterly data review and a deep-dive analysis of applicable measures is conducted	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
delays and /or introduction of additional interventions are timely and well thought out. The MCO should be mindful of the objectives and goals as well as the impact to the members over the life of the PIP to monitor ongoing progress.	by the PIP specific workgroup, to assess current PIP data reported and evaluate if additional analytic reporting options should be developed to further support PIP intervention measurement and tracking. The Plan maintains a PIP monitoring work plan to track intervention and data/reporting needs to ensure accountability for intervention oversight and data deliverables. In 3Q2021, an additional physician was assigned to the MLTSS Medicaid PIPs to assist with PIP oversight and alignment with PIP objectives and goals. In 4Q2021, the quarterly deep dive analysis was expanded to include PIP intervention demonstration assessment to monitor data analysis and improvement in PIP intervention performance. Amerigroup will continue to monitor its PIP processes related to opportunities for improvement. The QM PIP lead continues to work with all involved operational areas and reporting departments to ensure accurate data collection, review and analysis, and timely intervention implementation.	
The Plan should review each section of the PIP process to ensure that each section is updated according to new information, such as changes in process in Methodology, ensuring that changes are accurately documented for monitoring, analysis and a comprehensive evaluation is ongoing throughout the improvement process for understanding progress and impact to the membership.	Amerigroup has incorporated a quality review process that ensures all changes/updates pertaining to the PIPs are captured in the PIP's change table and outlined under the appropriate section(s) of the PIP where the changes/updates are applicable. Amerigroup continues PIP-specific workgroups with dedicated staff leads within the operational teams to work with the QM PIP lead and a dedicated physician, to support the analysis and evaluation of PIP activities. A team of data analysts is utilized in order to expand data collection, analysis, and monitoring to ensure a more comprehensive review. A quarterly data review and a deep-dive analysis of applicable measures is conducted by the PIP specific workgroup, to assess current PIP data reported and evaluate if additional analytic reporting options should be developed to further support PIP intervention measurement and tracking. The Plan maintains a PIP monitoring work plan to track intervention and data/reporting needs to ensure accountability for intervention oversight and data deliverables. In 3Q2021, an additional physician was assigned to the MLTSS Medicaid PIPs to assist with PIP oversight and alignment with PIP objectives and goals. In 4Q2021, the quarterly deep dive analysis was expanded to include PIP intervention demonstration assessment to monitor data analysis and improvement in PIP intervention performance. As of 1Q2022, the QM PIP lead conducts monthly data review to ensure changes are documented throughout the PIP template. Amerigroup will continue to monitor its PIP processes related for opportunities for improvement. The QM PIP lead continues to work with all involved operational areas and reporting	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	department to ensure accurate data collection, review and analysis, and timely intervention implementation.	
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County.	Hunterdon Medical Center (HMC) is the only hospital in this county and employs most of the physicians. Because of the Hospital's position, the physicians affiliated with the hospital-affiliated IPA will also not contract with Amerigroup. Amerigroup was granted a waiver from the current facility and primary care network requirements in N.J.A.C. 11:24:6.3(a)1 for Hunterdon County that expired in July 2013. Multiple waiver renewal requests have been submitted to DOBI and DMAHS to extend the waiver, but the agencies have not issued a response to date.	Addressed
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Warren County.	Amerigroup has attempted to cure the pediatrics deficiency that exists in the Phillipsburg 08865 area, but these efforts have uncovered that the St. Luke's hospital system owns the vast majority of PCP practices in this area. If contracting with the Hospital is successful, Amerigroup will also be able to pursue contracts with their affiliated physician practices and we can anticipate that this deficiency will be cured.	Addressed
The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties.	Since 2012, Hunterdon Medical Center (HMC) has refused to contract with another Medicaid MCO despite numerous attempts made by Amerigroup to do so. Outreaches were made in November 2021 and again in July 2022. Amerigroup is currently in active negotiations with St. Luke's-Warren Campus and we expect to finalize a contract by the end of this year. In November 2020 Amerigroup submitted to DOBI and DMAHS a request for a waiver from the current facility and primary care network requirements in N.J.A.C. 11:24:6.3(a)1 for Warren County but a response has not been received to date. Amerigroup continues to outreach provider for contracting.	Addressed
The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care.	Amerigroup continues recruitment efforts to expand our Adult Social Day Care services. We are currently in the process of working with Adult Medical Day Care Centers in our network about expanding services to add social adult day care. There is a known lack of Adult Social Day Cares in counties where deficiencies exist. Amerigroup is continuing our routine quarterly efforts to identify new Leads by researching the four (4) competitor Medicaid plans' networks, making outreach to County Offices on Aging, and reviewing Web search options. As these facilities are not licensed by the State, we are unable to utilize State licensing board data to identify these facilities.	Addressed
The MCO should continue to focus on improving after-hours availability statewide.	Providers are educated about Appointment Availability and After-Hours Standards via provider newsletters and ongoing provider training conducted by the Provider Experience team. Amerigroup conducts the appointment and after- hours surveys annually. Non-compliant providers are required to provide a formal correction plan. Providers that are non-compliant are resurveyed. Providers that continue to be non-compliant are reviewed for additional remediation up to and including termination. Member grievances concerning	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	availability are addressed with providers by the Provider Experience team. Health Care Management is available to assist Members with appointment scheduling.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, AGNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Amerigroup routinely monitors and leverages HEDIS reporting to evaluate the plan's performance against the NCQA 50th percentile. Amerigroup maintains a HEDIS intervention work plan, which identifies barriers and monitors interventions. Intervention success or deficiencies are reviewed on a monthly and/or quarterly basis and are submitted to the State for review on an annual basis and/or upon request. Amerigroup also collaborates with various departments (i.e., Medical Affairs, Member Engagement, Provider Experience, Pharmacy, Healthcare Services, BH, EPSDT teams) through the HEDIS workgroup, and via targeted member and provider engagement initiatives. The HEDIS workgroup is leveraged to create, improve and/or modify interventions in the work plan or identified through HEDIS performance analytic reporting, with the goal of addressing gaps in care and improving members' health outcomes for HEDIS measures to meet and/or exceed the NCQA 50th percentile. Amerigroup also partners with our delegated vendors (i.e., Liberty Dental and Versant Health (formerly Superior Vision) to develop initiatives that drive improved performance for related HEDIS measures (i.e., Annual Dental Visit (ADV) and Eye Exam for Patients with Diabetes (EED)).	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	Amerigroup continues to monitor CAHPS measures that fall below the NCQA 50th percentile on a quarterly basis through reporting and has implemented and monitors the interventions listed on the CAHPS work plan, which is sent to the State for review annually. Amerigroup also convenes a Member Satisfaction workgroup of associates from various departments to review CAHPS results and strategize new interventions, as well as reviews the CAHPS workplan submitted to the state, with the Quality Management Committee (QMC) for feedback.	Addressed
AGNJ should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	Amerigroup Care Management (CM) managers have educated CM staff during team meetings about the importance of verifying preventive services with reliable sources and aggressive outreach and follow-up regarding these services. Care managers will continue to aggressively outreach members to educate about preventive services. They are outreaching providers, including vision and dental providers, to obtain assistance with educating and scheduling members for their services. Care management staff are continuing to coordinate transportation as needed and obtaining a reliable source to verify completion of preventive services. In addition, a reliable source preventive services summary note template was created and is now used by all care managers.	Addressed
AGNJ should address the deficiencies noted in the following areas: • DDD – Preventive Services, and all	The Amerigroup DDD CM manager has educated staff about the importance of verifying reported preventive services during team meetings. Staff have been trained to verify reported preventive measures with a reliable source such as a member's PCP, Perform Care or DDD staff. They have been tasked with provider outreach and collaboration to assist with education and appointment setting for members. These actions will assist members with keeping up to date	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
CM element specific deficiencies noted in the review.	with preventive care. In addition, a reliable source preventive services summary note template was created and is now used by all care managers for DDD members. Our care management discharge planning process was updated, and the DDD care management staff have been educated on these updates. Upon education and training the team now uses the post discharge management process to follow our DDD members who have been hospitalized. This process includes outreach to the member, their PCP and community agencies to coordinate health care needs. The DDD care manager will then follow up with the member weekly to assess if discharge plans were adequate. If a member is unable to be contacted post discharge a letter is sent and the provider is contacted. During this process, a Care plan is created and monitored for outcomes or any necessary updates.	
AGNJ should address the deficiencies noted in the following areas: • DCP&P – Preventive Services, and all CM element specific deficiencies noted in the review.	The Amerigroup DCP&P CM manager has educated DCP&P staff during team meetings on the importance of verifying reported preventive services with a reliable source. Our DCP&P Care Management Staff have been trained to verify member reported preventive services with a reliable source such as the member's PCP, DCP&P Nurse, School Nurse or Database such as NJIIS. A reliable source preventive services summary note was developed to ensure that CM staff addressed age and developmentally appropriate preventive services. All staff were trained to use this note at our team meetings.	Addressed
AGNJ should address the deficiencies noted in the MLTSS - NF 2021 CM Review for elements that scored below 86%.	Performance Measure #8 Amerigroup should ensure that the member's Initial Plan of Care is developed within 45 days of enrollment into the MTSS program. MCO Response: Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, containing a status for Plan of Care completion for all members new to MLTSS. A risk summary report is compiled by the Operations Team and shared with the management team to identify cases at risk for noncompliance. A dedicated clinical manager has been assigned to review the daily snapshot report and follow up with management on Care Manager POCs that are at risk for timely completion. Ongoing internal auditing addresses compliance to this element in real time allowing the LTSS Compliance Team to trend data, which is reviewed with the Clinical Management team. The LTSS Compliance Team provides department level reeducation, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Performance Measure #9: Amerigroup should ensure that the Care Manager reviews the Member's Plan of Care within 30 days of the Member's MLTSS anniversary and as necessary. MCO Response: Amerigroup utilizes a Daily Snapshot tracking report, shared with the MLTSS management team, containing a status for Care Management visit and Plan of Care completion timeframes for all members enrolled in MLTSS. A risk summary report is compiled by the Operations Team	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	and shared with the management team to identify cases at risk for noncompliance. Ongoing internal auditing addresses compliance to this element in real time allowing the LTSS Compliance Team to trend data, which is reviewed with the Clinical Management team. The LTSS Compliance Team provides department level reeducation, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review. Amerigroup should ensure the Plan of Care is signed and developed in collaboration with the Member and mailed within 45 days of MLTSS enrollment. MCO Response: Amerigroup's clinical system, Health Innovations Platform (HIP), assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements for elements including the Plan of Care Mailing. In addition, the Healthy Innovations system has been configured to capture member signature and Care Manager signature on every Plan of Care in order for the assessment to appear complete and enable submission in the clinical system. Ongoing internal auditing addresses compliance to this element in real time allowing the LTSS Compliance Team to trend data, which is reviewed with the Clinical Management team. The LTSS Compliance Team provides department level reeducation, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review. The Care Manager should confirm that there is documentation of the Member's participation in at least one Facility IDT meeting annually. MCO Response: Amerigroup's clinical system, Health Innovations Platform (HIP), assigns due dates to visits on Care Manager caseloads using configured timeframes based on contractual requirements. Amerigroup's current interventions include medical management staff adding Facility Interdisciplinary Team (IDT) Meeting Tasks, in HIP, for nursing facility members, with a due date of 5 and 11 months from MLTSS enrollment. Amerigroup developed reporting to capture statuses of these Tasks created in the Healthy Innovations Platform (HIP), related to the Facility Interdisciplinary Team (IDT) Meeting. The updated reporting for HIP tasks was completed for production, April 2022 and is currently in use to assist in compliance auditing and monitoring. This report is new and will continue to develop as Amerigroup audits and finds new ways to improve our care management processes. Completion of the Task confirms care manager attendance and participation at the NF IDT. Amerigroup should ensure the MLTSS Care Managers discusses payment liability and reviews the Member's placement and services timely. MCO Response: Ongoing internal auditing addresses compliance to these elements in real time allowing the LTSS Compliance Team to trend data, which is reviewed with the Clinical Management team. The LTSS Compliance Team provides department level reeducation, as needed,	

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Additionally, these requirements are captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review. Prior to March 1, 2020, Amerigroup's MLTSS Care Managers should have utilized the New Jersey Choice Assessment (NJCA) to assess Members. MCO Response: Amerigroup members who have a change in level of care/condition that warrants a Significant Change Visit to occur in order to ensure member safety in current Living Arrangement will receive a visit to update to all LTSS documents is made, including the NJCA. Dedicated associates have been designated to monitor the census reports (i.e., identifying members who have been admitted or discharged from an acute inpatient or rehab setting), to task the care manager with a significant change task. This will prompt the care manager to schedule a significant change visit in order to update all assessments, including the NJCA. Amerigroup has modified Desktop Processes to implement a process change to ensure that the NJCA is completed for NF to HCBS transitions. The Transitions Coordinator will complete the NJCA Significant Change assessment, prior to transition to the community (change in living arrangement). The Transitions Coordinator will track and record all Transition IDTs on our internal SharePoint site, including completion of the NJCA, when applicable. This gives the Management Team a line of vision on all pending and completed NF to HCBS transitions, to ensure compliance for NJCA completion. Amerigroup has added these elements to the Implemented Internal Auditing process to trend elements related to compliance of NJCA completion. The LTSS Compliance Team provides department level reeducation, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review. The Care Manager should ensure the Member's Plan of Care is reviewed, revised if applicable, and signed by the Member/POA. MCO Response: All Care Managers are educated upon hire, and quarterly, regarding the need to review and revise the member's POC as needed and obtaining member signature. Care Managers are educated on the need to revise the member's POC upon post hospitalization, change in status, any update to services, etc. The Care Manager will review the initial POC and revise the POC as applicable in the HIP system, which will trigger the requirement for Care management review with member and obtaining the member signature. The Healthy Innovations system has been configured to capture member signature and Care Manager signature on every Plan of Care in order for the assessment to appear complete and enable submission in the clinical system. Ongoing internal auditing addresses compliance to this element in real time allowing the LTSS Compliance Team to trend data, which is reviewed with the Clinical Management team. The LTSS Compliance Team provides department level reeducation, as needed, while the Clinical	

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Management Team addresses areas of opportunity with individual Care Managers. Additionally, this requirement is captured in the MLTSS Care Management Desk Top Processes and Policy and Procedures for staff review.	

[1] **Addressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2023.

HNJH Response to Previous EQR Recommendations

Table 52 displays HNJH's progress related to the *State of New Jersey DMAHS, Horizon New Jersey Health Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of HNJH's response.

Table 52: HNJH Response to Previous EQR Recommendations

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
HNJH should address the PIP validation elements that were determined to be not met or partially met.	Horizon will continue to review all comments provided by IPRO and will continue to address elements that were partially met or not met to investigate opportunities to improve and clarify the PIP validation elements. IPRO feedback from April and August submissions are addressed and updates are incorporated in subsequent PIP submissions as well as being noted in the Change Table when applicable.	Addressed
The MCO should continue to review and revise their data for accuracy in the MLTSS PIP. The MCO should also continue to evaluate methodology, performance indicators, and timeframes to ensure positive outcomes.	Horizon will continue to review reported PIP data for accuracy and consistency prior to the April and August submissions. Revisions and changes to the PIP are addressed in subsequent submissions and noted in the Change Table when applicable. Following initial completion of the draft submissions, Horizon utilizes a multi-tiered, internal review process, involving the QM department, Analytics and Care Management when applicable. After all internal reviews have been completed and suggestions/revisions made, a final review of the completed document is done prior to submission. Horizon will continue this internal, multi-tiered review process and will make it a point moving forward, to pay close attention to data accuracy.	Addressed
The MCO should continue to expand the Dental/Specialty Dental network in Atlantic County. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers.	Horizon expanded its dental network in Atlantic County in August 2021. Horizon contracted with a dental group that opened three distinct offices in zip codes where there were deficiencies. The new offices are in Atlantic City, Brigantine and Mays Landing. Currently, Atlantic County is at 95.00%, which meets the requirements and addresses the deficient coverage area for Dental/Dental Specialty providers.	Addressed
The MCO should continue to expand the MLTSS network	Horizon's goal is to expand the MLTSS network to include at least two servicing providers in every county for Adult Social Day Care. Unfortunately, there are a limited number of Social Adult Day Care	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
to include at least two servicing providers in every County for Adult Social Day Care.	(SADC) providers in New Jersey. In July and August of 2022, Horizon reached out to participating Adult Medical Day Care (AMDC) providers throughout the state encouraging them to expand their business to include Social Adult Day Care. Several Adult Medical Day Care providers have agreed to collaborate with Horizon as Social Adult Day Cares, and the necessary documents are in the process of being sent to those providers so that the credentialing process can begin. Please see the detailed update by county below. We will continue reaching out to our AMDC network to expand the MLTSS Social Adult Day Care network. We have sent the necessary information to these facilities to complete the credentialing process and expand the MLTSS network: **Union County-** Town Square of Amber Court in Elizabeth agreed to become a participating provider. **Mercer County**- Prestige of Ewing agreed to become a participating provider. **Camden County**- Prestige AMDC in Cherry Hill agreed to become a participating provider. Additionally, Promising AMDC of Passaic County joined the network on 4/1/22, which expands the network in that county. Bayonne AMDC (Hudson County) and Prestige of Marlton (Burlington County) agreed to become participating providers, which would improve accessibility in those counties.	
The MCO should focus on improving appointment availability for dental providers, adult PCPs, specialists, and behavioral health providers, as well as improve after-hours availability.	Horizon is focused on educating dental providers, PCPs, specialists and behavioral health providers to improve appointment availability and after-hours access. Due to staffing shortages and transitioning back to the office during the pandemic, providers have been faced with challenges meeting these standards. Recognizing the importance of these requirements, Horizon has established a multifaceted effort to work with our network and bring them into compliance. 1) Horizon provided education to all providers (including dental providers, PCPs, specialists and behavioral health providers) on appointment availability and 24-hour access standards. Education was provided via monthly webinars, articles in our Provider Pulse Newsletter, Provider Portal News alerts, as well as telephone outreach to offices that are non-compliant with the standards. The telephone outreach is a new initiative that began in Q3, 2022. 2) Providers that fail an audit (including dental providers) receive education during the audit, written notification and must submit a corrective action plan. They are also subject to re-audit to ensure they are implementing the corrective action. 3) Additional follow up is done to ensure provider office procedures are updated and effective so that they will pass when the next audit is performed. All providers who submitted a CAP for the 24 Hour Access Survey and failed the re-audit will receive additional telephone outreach with one on one training. In addition, those providers will also have follow up made by the Network Specialist in the months following to monitor the progress of their Corrective Action. Starting in Q3, 2022, providers who failed four or more questions on the Appointment Availability Survey will receive education from the	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Network Specialist who will assist them in identifying barriers and implementing their improvement plan. 4) Beginning in Q4 2022, educational outreach will be included in our large groups that already have quarterly meetings with Internal Horizon staff (such as Value Based Groups). 5) Appointment Availability standards as well as the Telephone Access standards are posted online under the Administrative Policies tab on the Provider Portal. This posting makes the policies more visible and available to the providers.	
The MCO should ensure FIDE SNP members are included in the Breast Cancer Screening Measure.	The Medicaid membership was updated in May of 2021 to include FIDE SNP in HEDIS reporting as required. This update was made for HEDIS Measurement Year 2020. The population is monitored monthly to ensure compliance. This closes the gap and ensures that FIDE SNP members are included in the Breast Cancer Screening Measure.	Addressed
The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO Performance Measure validation.	Horizon is ensuring that all reporting includes appropriate MLTSS members. All state updates are reviewed and changes to reporting are being applied, as necessary. A plan is in place to ensure state reporting follows the required specifications. Additionally, Horizon will outreach to IPRO and DMAHS for clarifications that may be needed to ensure alignment with reporting expectations.	Addressed
The MCO should ensure new member quarterly outreach is tracked to verify the enrollees understanding of the MCO's procedures and available services and made available to DMAHS per Contract requirements.	Horizon has an ongoing Medicaid Enrollee Survey program conducted by the Plan's Member Experience Team. An online survey is completed quarterly with new enrollees that includes topics such as overall satisfaction, benefits and coverage, plan understanding, quality of care and more. Annually, a report is completed that summarizes the results of the surveys. Additionally, all new enrollees are welcomed to the plan with a phone call where they are provided with education on plan benefits and services offered by HNJH.	Addressed
The MCO should focus on the HEDIS quality-related measures, which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their	HNJH continues to focus on improving Quality outcomes for our members, and in our effort to do so we monitor measure performance on an ongoing basis. Barrier analysis is completed and interventions are developed to improve performance. HEDIS measure performance is reviewed during the HEDIS Workgroup with a report out to the Quality Improvement Committee. Provider offices continue to report barriers related to the impact of COVID-19, which include member reluctance to go into offices and provider staffing shortages. In 2022, several Pediatric and Adult initiatives are underway to improve performance of measures that fell below NCQA 50thpercentile. These initiatives include: • A new Member Rewards Program targeting CIS and LSC measures (Pending) • Continuation of Prenatal/Postpartum rewards (Pending) and weekly Post-partum flier to members	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
respective benchmarks for more than one reporting period.	• IVR Campaign to educate members on Diabetes Care/Management, awareness/education on Cervical and Breast Cancer Screening and Asthma Medication Ratio. • Pediatric Immunization IVR campaign for members' ages 15 months old falling behind on the immunization schedule and pediatric wellness letter/Immunization schedule sent to newly enrolled members ages 0-15 months. Additionally, Happy Birthday postcards are sent to members turning 1 reminding their caregivers of wellness visits, shots, lead and dental screening. • For providers participating in the Results and Recognition (R&R) Program, a Clinical Quality Improvement Liaison is assigned to each provider site who shares provider gap reports on a regular basis. Live webinars are held quarterly educating providers on various measures. The R&R program provides several resources to the provider through the Quality Resource Center including billing tip sheets, HEDIS Guidelines, Provider Manual and recorded webinars. • The Behavioral Health (BH) team continues to launch both member and provider facing interventions focused on behavioral health measures. The BH team has launched monthly provider webinars in 2022 focusing on HEDIS measures and best practices. The team is targeting high volume providers with individual outreach and partnership to meet goals. Additionally, the team is in the process of launching an IVR campaign for members targeting measures below 50th percentile and have implemented member educational mailers for select measures in 2022.	
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	The Quality Management Team has been working very closely with Case Management, Member Experience, Network and Member Services teams to address all CAHPS measures with a targeted focus on measures not meeting the 50th percentile. Provider CAHPS education is being provided through multiple channels, including a CAHPS Coaching Program, monthly webinars and the Provider Newsletters. The CAHPS coaching program was implemented in Q3 of 2021 and was structured to support provider organizations to improve member experience. The program provides dedicated CAHPS coaches who develop individualized work plans and provide ongoing support to the providers. The program was enhanced in 2022 to expand the number of providers enrolled in the program and will cover roughly 675 providers who serve over 500,000 HNJH members. The program also includes monthly webinars for all providers and office staff regardless of enrollment in the program. The webinars are focused on all CAHPS measures including coordination of care, access to care, provider communication, appointment availability and member experience. Additionally, Horizon developed CAPHS related articles for the Q3 and Q4 Medicaid Member Newsletters. The articles will include information on access to healthcare visits including telehealth options and topics that members should talk about during their PCP visit. Topics include risk for falls, blood pressure, BMI, vaccinations, preventative health screenings and medications. Members are reminded to write down any questions and bring a list of their medications to the visit to ensure all questions are addressed at the time of the visit. The QM, Member Experience and	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Service teams are evaluating the member's verbatim comments left on the member experience and proxy surveys and on post call surveys to identify areas of opportunity to improve member satisfaction. The CAHPS interventions are tracked and updated on a weekly basis to ensure interventions are on track and new interventions are developed based on identified opportunities and CAHPS scores that are below the 50th percentile.	
HNJH should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	Based on the 10/18/2021 CM Audit Corrective Action Plan, Horizon continues to monitor the following areas to address CM specific deficiencies noted in the review: - In Q4, 2021 improved reporting was implemented to measure and track compliance on initial outreach to new enrollees - In Q4, 2021, the Case Management Dashboard was enhanced to ensure timely completion of the Comprehensive Needs Assessment (CNA), or documented Aggressive Outreach efforts in the absence of or untimely completion of the assessment; within 30 days following an IHS score of 5 or greater. -In Q3, 2021, the Case Management Dashboard was updated to track timely completion of the Care Plan, or documented Aggressive Outreach efforts in the absence of or untimely completion of a care plan, within 30 days of CNA completion -Frequency of care coordination efforts through completed Care Coordination Surveys -Members are educated on preventative services through a series of annual mailers. Horizon's workflow was updated in Q4, 2021 and it dictates completion of a Preventative Health Survey upon confirmation of preventative services by a reliable source.	Addressed
HNJH should address the deficiencies noted in the following areas: • DDD – Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	Based on the 10/18/2021 CM Audit Corrective Action Plan, Horizon continues to measure the following areas to address CM deficiencies noted in the review: - In Q4, 2021, the Case Management Dashboard was enhanced to ensure timely completion of the Comprehensive Needs Assessment (CNA), or documented Aggressive Outreach efforts in the absence of or untimely completion of the assessment; within 45 days of enrollment for the DDD - In Q3, 2021, the Case Management Dashboard was updated to track timely completion of the Care Plan, or documented Aggressive Outreach efforts in the absence of or untimely completion of a care plan; within 30 days of CNA completion - Members are educated on preventative services through a series of annual mailers. Horizon's workflow was updated in Q4, 2021 and it dictates completion of a Preventative Health Survey upon confirmation of preventative services by a reliable source for the DDD members.	Addressed
HNJH should address the deficiencies noted in the following areas: • DCP&P –All CM element specific	Based on the 10/18/2021 2021 CM Audit Corrective Action Plan (CAP), Horizon continues to measure the following areas to address CM deficiencies noted in the review: -In Q4, 2021, the Case Management Dashboard was enhanced to ensure timely completion of the Comprehensive Needs Assessment (CNA), or documented Aggressive Outreach efforts in the absence of or untimely	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the review.	completion of the assessment; within 45 days of enrollment for DCP&P members - In Q3, 2021, the Case Management Dashboard was updated to track timely completion of the Care Plan, or documented Aggressive Outreach efforts in the absence of or untimely completion of a care plan; within 30 days of CNA completion -Members are educated on preventative services through a series of annual mailers. Horizon's workflow was updated in Q4, 2021 and it dictates completion of a Preventative Health Survey upon confirmation of preventative services by a reliable source for DCP&P members.	
HNJH should address the deficiencies noted in the MLTSS – HCBS 2021 CM Review for elements that scored below 86%.	As per the MLTSS – HCBS 2021 CM Audit Corrective Action Plan (CAP) submitted on 2/14/22, Horizon continues to monitor the four (4) areas identified in the CAP as opportunities for improvement (scoring below 86%): 1. Ensuring Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits are to occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS; 2. Ensuring that MLTSS Care Managers conduct a telephonic visit within 24 hours for urgent/emergent situations; 3. Ensuring that Member Back-up Plans are reviewed and revised if applicable, at least quarterly for Members residing in the community; and 4. Ensuring that Care Managers complete a telephonic visit within ten (10) business days of a Member's discharge from an institutional facility to a HCBS setting. In an effort to address those 4 areas, HNJH took the following steps in 2021: Updated and reissued numerous MLTSS Care Manager operational workflows; re-educated Care Manager staff at team meetings; updated the Tableau Dashboard to flag member visits that are due with a newly set 87 day cycle versus the 90 day cycle to improve timeframe compliance; and management reviewed with supervisory leadership the MLTSS Tableau Dashboard and the Unsigned Documents Report for oversight with regard to ongoing monitoring of Back Up Plan compliance, timely outreach and follow-up after a nursing facility discharge. Additionally, the State requested a Quarterly Follow-Up for this CAP on 8/1/22 and a response was provided in turn by Horizon on 8/9/22. In that communication, HNJH described the monitoring efforts in place to improve compliance, which included: 1. The standards of timely face-to-face assessment/visits being completed at least every 87 days for members in private residences, community alternative residential services settings and pediatric SCNF members was reviewed at the 3/9/22 MLTSS Care Management (CM) Supervisors meeting.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. The Face-to-Face Visits Operational Workflow was updated and redistributed to staff on 4/1/22 and 6/1/22. 3. The Analytics request to update the Tableau Dashboard specification from 90 to 87 days was made on 6/1/22 and the system enhancement was tested and fully operational effective 6/23/22. 4.Two quarterly reports were analyzed to consider timeliness compliance between CYQ1 Jan-Mar 2022 and CYQ2 Apr-Jun 2022. Results indicated a month to month increase in timeliness compliance -- with quarterly rates improving from CYQ1 = 88% to CYQ2 = 93%. These findings were shared with the MLTSS Regional Managers and Care Management Supervisors. The next quarterly report will be run in October/November 2022. Face to Face, Timeframe Compliance Monitoring continues to be a standing agenda item at monthly Care Management Supervisor staff meetings.	
HNJH should address the deficiencies noted in the MLTSS - NF 2021 CM Review for elements that scored below 86%.	Horizon submitted its MLTSS – NF/SCNF 2021 CM Audit Corrective Action Plan (CAP) on 11/30/2021. Horizon continues to monitor the four (4) areas identified in the CAP as opportunities for improvement (scoring below 86%): - Ensuring MLTSS Care Managers confirm that there is documentation of participation in at least one Facility IDT meeting annually; - Ensuring that onsite review of member placement and services is timely; - Ensuring MLTSS Care Managers discuss payment liability with members; and - Ensuring there is sufficient communication of the PASRR Level I to OCCO, as applicable to a NF/SNCF transfer. In an effort to address the 4 areas of opportunity, HNJH took the following steps in 2021 and 2022: Updated and reissued numerous MLTSS Care Manager Operational Workflows; re-educated Care Manager staff at team meetings; communicated with facility-based providers about the importance of collaborating with assigned care management staff related to member care planning issues/meetings; held multiple care management MLTSS CM NF/SCNF Workgroup meetings specifically for staff designated to serve facility-based members; revisited preparation of internal case files and reconsidered what documentation was used as evidence for the NF/SCNF Audit; reviewed and redistributed the MLTSS Member Rights & Responsibilities Sign Off Sheet to all Care Management staff and included emphasis on the review of patient payment liability when applicable for NF, SCNF, and AL members; and Included additional training and guidance for staff regarding the appropriate steps for PASRR documentation. Additionally, the State requested two Quarterly Follow-Ups for this CAP in April and July 2022 and responses were provided in turn by Horizon on 4/22/22 and 7/29/22. In those communications, HNJH described the monitoring efforts in place to improve compliance, which included: 1) MLTSS CM Management re-educated the Nursing Facility Care Managers on using the appropriate contact notes when documenting	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	provider outreach and participation in NF IDT Care planning rounds, and 2) Enhanced its NF_ALR report to include tracking on the contact note types for IDT meetings, IDT Inquiry and Nursing Facility Care Plan attachments. 3). HNJH Provider Contracting & Services issued a fax blast to 372 facilities to re-distribute the MLTSS Facility Alert Form and cover letter, which reached all NF/SCNFs in Horizon's provider database to remind and encourage those facilities to communicate with HNJH care management about resident matters, such as upcoming IDT Care Planning meetings, hospital admissions, and other important member events. 4). The MLTSS Department continues to use its NF_ALR Monitoring Report, reflective of data within the member Electronic Medical Management System to review the MLTSS population residing in Nursing Facilities and care management involvement with IDT care planning rounds. Analysis of the most recent quarterly review determined a 6% increase in compliance since the previous quarter. There remains continued opportunity for improvement for both Care Management documentation efforts as well as for facility provider re-education; and the NF_ALR Monitoring Report will remain in use to identify trends over time, support staff re-education as needed, and work toward ongoing quality improvement.	

[1] **Addressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2023.

UHCCP Response to Previous EQR Recommendations

Table 53 displays UHCCP's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Community Plan of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of UHCCP's response.

Table 53: UHCCP Response to Previous EQR Recommendations

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address the PIP validation elements that were determined to be not met or partially met.	Reducing Avoidable ED Utilization – Medicaid PIP Overall score – 96.9% • UHCCPNJ was partially compliant with 1a. a concern was identified with an aspect of the Change Table pages 2-5. Based on IPRO recommendation, the MCO updated all dates in the Change Table to correspond to the actual dates when the changes were made. MLTSS Gaps in Care PIP – Flu and Pneumonia Vaccination and PCA Initiation PIP- Overall Score – 85% • UHCCPNJ was partially compliant regarding Methodology subcomponent 3g. The MCO determined that NJ Choice was the best tool for the MCO to calculate member vaccination rates with flu and pneumococcal vaccines. The NJ Choice data was used to calculate the	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	performance indicators from the onset of the PIP and accepted by auditor previously. Similar questionnaire model is used in CAHPS surveys. The NJ Choice is completed annually for each member. The NJ choice assessment was restarted in November 2021 after the state lifted the suppression of NJ Choice face to face visits which was in effect due to the Covid PHE. The MCO used in MY2, an approximation of the performance indicators based on the member answers given in the quarterly Face-to-Face assessments, because NJ Choice data was not available for the time period due to the COVID-19 pandemics. This temporary assessment approximation was not used as a performance Indicator vaccine rate, but only for internal monitoring of vaccination rates for education of the members. As stated Previously the NJ Choice tool resumed November 2021 and calculations for the final PIP were based on NJ Choice data calculations. As recommended by the auditor to perform a claims review, the claims revealed the rates were significantly lower than the rates reported by members in their NJ Choice assessment. This was due to members receiving vaccinations at sites not billing e.g., community centers, religious centers, etc. • UHCCPNJ was partially compliant regarding the data in the Intervention Tracking data table. When the denominator is zero, the rate needs to be NA. The MCO corrected the rate in Table 1b (both parts), where numerator and denominator were both 0. The rate was corrected from 0% to N/A. • UHCCPNJ Early Intervention PIP and the Adolescent PIP had no PMs or NMs and both received 100%.	
The MCO should implement planned interventions in a timely manner to have an effective impact on the outcome of the MLTSS PIP.	UHCCPNJ reviewed Table 1b – Measures (Section A, Gaps in Clinical Care). Quarterly Reporting of Rates for Intervention Tracking The MCO reported low rates of follow up phone calls to members to reinforce flu and pneumococcal vaccination education and provide care coordination to receive the vaccinations. The MCO identified that care management staff were documenting their follow up calls through reminders in the ICUE system, instead of follow-up assessments. The MCO worked with the clinical data team to review this documentation. The review demonstrated higher intervention rates, and the new rates were documented in the August 2022 PIP submission. UHCCPNJ reviewed Table 1b – (Section B, Gaps in MLTSS PCA Service). Quarterly Reporting of Rates for Intervention Tracking Measures. The MCO reported low rates of follow up interventions to initiate PCA services. The MCO identified documentation of follow up as the reason for the low rates. The care management staff were documenting their follow up in notes in the ICUE system. Complete chart review indicated that all necessary follow up for PCA initiation was done by the care managers. Starting on March 7, 2022, all questions related to the PCA services, flu, and pneumococcal immunizations were incorporated into the Plan of Care (POC) template, which care managers complete quarterly for all MLTSS HCBS members. This change will sustain PIP improvement by ensuring that service needs will always be addressed for new enrollees, and they will also be addressed quarterly for all members.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Telephonic care coordination with the PCA agencies and telephonic care coordination for vaccinations will continue.	
The MCO should continue to address the hospital access deficiencies in Atlantic and Cumberland Counties.	UHCCPNJ has successfully contracted with Inspira Medical Centers in Elmer, Mullica Hill and Vineland effective 9/1/2022. This in-network participation agreement should satisfy the GeoAccess deficiencies in Atlantic and Cumberland counties.	Addressed
The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care.	UHCCPNJ's Network Contracting team has contracted with all Social Day Care providers who are known and who have agreed to participate in the UHCCPNJ network. The State site does not list Social Day Care provider options. Therefore, UHCCPNJ has no other Social Day Care providers to outreach to for contracting.	Addressed
The MCO should continue to focus on improving appointment availability for Adult PCPs, Pediatric providers, OB/GYN providers, high-volume Specialists, and Behavioral Health providers, as well as improve after-hours availability statewide.	UHCCPNJ has a process in place whereas if there are any issues with a member seeking an appointment with an in-network provider within a requested time frame, the member may call member services to request assistance with scheduling that appointment. We will add language to the member handbook to communicate to members that they may contact Member Services for assistance in scheduling an appointment with a provider by them calling the provider on the member's behalf. Our quarterly appointment availability reporting demonstrates that there are providers who are available for appointment scheduling within DMAHS requirement timeframes. Our Member Services team can help to schedule an appointment on behalf of the member, with the provider for specialty being requested, within those timeframes. UHCCPNJ is continually working with any provider practices who have been found through survey reporting do not meet the after-hours response requirement, in order to comply with DMAHS contract standards.	Addressed
The plan should ensure that reporting is finalized for the conditions: aspiration pneumonia, injuries, fractures, and contusions, decubiti, and seizure management.	UHCCPNJ reviewed the report with IPRO during the Annual Audit in September 2021 and demonstrated that updates and revisions were complete. The report for the four diagnosis is produced on a regular basis, analyzed by the Quality Management team, and presented at the quarterly PAC and QMC meetings. The report analysis is shared with the Care Management teams for review and member education and outreach as appropriate.	Addressed
The MCO should ensure that pre-onsite documentation not only describes processes, but that it	UHCCPNJ has a process in place as part of standard audit support procedures, upon receipt of a regulatory audit notice, our Compliance Team enters the information into a tracking system and notifies the health plan of the upcoming audit. The Audit Manager and Compliance Officer, arranges the systemic support for all audits, tracks various deliverable (universe and narrative) dates and organizes	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
also shows implementation of policies and procedures.	preparation meetings with all stakeholders. Any changes to the submission guide/elements, supplied by the auditor, are reviewed against prior audits, and discussed with stakeholders noting changes and required new actions to demonstrate compliance. Prior to uploading final documentation, UnitedHealthcare's assigned accountable owners, department leads and Compliance performance quality review to ensure that documentation provided demonstrates compliance with the element. UHC utilizes a Steering Workgroup to review all policies at least annually and upon notification of contract changes or regulatory changes. Policy owners ensures that pre-onsite documentation describes processes and provides evidence of implementation in compliance with applicable NJ Medicaid Contract, State & Federal requirements.	
The MCO should ensure the review of quality metrics, including a review of complaints/quality issues, at the time of Recredentialing, and that this is documented in the Core Medicaid PCP Recredentialing files, including delegated PCP providers.	UHCCPNJ continues to review and document the quality metrics, complaints, and quality issues for providers during their recredentialing cycle on the recredentialing checklist. Fourth Quarter 2021, a process was developed that would allow the MCO to review and document the same listed measures now for delegated providers. The process has not been finalized but will include that the delegated groups provide on a quarterly basis a list of their recredentialed providers for review. In the interim, the MCO uses the recredentialing monthly check list from the original date of credentialing to retrieve the delegated providers and review the listed measures during the recredentialing cycles.	Addressed
Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	UHCCPNJ completed a barrier analysis and developed interventions with input from key stakeholders including Behavioral Health, Pharmacy and Member Engagement. A HEDIS workplan is maintained and rates are regularly reviewed with focus on effectiveness of deployed interventions. The frequency and variety of clinic days was increased, and member rewards were expanded to include additional measures. UHCCP NJ worked with providers to increase service levels to those of pre-PHE levels and provided offices with "Best Practice" strategies for scheduling, documentation, and coding in an effort to close care opportunities. Educational materials for providers and members are shared in a variety of media.	Addressed
The MCO should ensure accurate and timely submissions related to MLTSS Performance	UHCCPNJ will revise the review process to include additional layer of reviewer/s to validate responses including supporting documentation prior to State submission. Requirements are being defined to capture a more detailed review process including data validation by clinical operations team. Managers/designated clinical reviewers and	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Measure clinical documentation.	operations team will be trained on the review process to ensure accurate and timely submissions.	
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	UHCCPNJ addressed all the Adult and Child CAHPS scores performing below the 50th percentile. A detailed CAHPS workplan was developed to include each measure, the barriers, the previous interventions, the new/ongoing interventions, the monitoring systems, and leadership accountable. A CAHPS Task force was developed which is representative of division leadership and staff from all divisions, e.g., Quality. Operations, MLTSS, Care management, Provider Relation/Network, and the Member Call Center. This Task Force focused on interventions involving the Member, the Providers, and the Call Center representatives. This Task Force continues to meet monthly to ensure the interventions/initiatives are completed, evaluated, and continue through 2022/2023.	Addressed
UHCCP should address the deficiencies noted in the following areas: • GP – Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	UHCCPNJ continues educating newly enrolled and existing members on the importance of preventative services at each outreach. Provide age-appropriate educational materials in writing via preventative health mailings. Upon enrollment in Care Management (CM) educational materials are sent by non-clinical administrative coordinator. NJIIS immunization and lead reports for all members enrolled in CM are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during our routine monthly audits and random case reviews are conducted to ensure educational materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training.	Addressed
UHCCP should address the deficiencies noted in the following areas: • DDD – Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	UHCCPNJ continues educating newly enrolled and existing members on the importance of preventative services at each outreach. Provide age-appropriate educational materials in writing via preventative health mailings. Upon enrollment in Care Management (CM) educational materials are sent by non-clinical administrative coordinator. NJIIS immunization and lead reports for all members enrolled in CM are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during our routine monthly audits and random case reviews are conducted to ensure educational materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training.	Addressed
UHCCP should address the deficiencies noted in the following areas: • DCP&P-Preventive Services, and all CM element specific deficiencies	UHCCPNJ continues educating newly enrolled and existing members on the importance of preventative services at each outreach. Provide age-appropriate educational materials in writing via preventative health mailings. Upon enrollment in Care Management (CM) educational materials are sent by non-clinical administrative coordinator. NJIIS immunization and lead reports for all members enrolled in CM are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during our routine monthly audits and random case reviews are conducted to ensure educational	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
noted in the review.	materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training.	
UHCCP should address the deficiencies noted in the MLTSS – HCBS 2021 CM Review for scores below 86%, as well as all CM element specific deficiencies noted in the review.	Assessment: SCS completed on members who request MLTSS in the community setting and stored in the member's electronic record. The names and scores for those that scored a 3, 4, or 5 were entered on the state's SCS temporary Waiver Spreadsheet. SCS Temporary Waiver Spreadsheet was submitted timely before the 10th of the month. Tracked and reviewed by management team prior to submission. Compliance sends reminder emails of due date one week prior to the 10thCompliance tracks and monitors all submissions to the state. Outreach: Member Welcome Call – the assignment of the new members will be assigned to the CM teams one (1) week prior to the first of the month to allow the CM the ability to contact the member timely after the first day of the month. During the Welcome Call, the CM schedules time to complete the SCS and Plan of Care within 45 days of the enrollment notification. A report was developed to monitor the enrollment date and the date the SCS, and Plan of Care are due. This report is monitored daily by the managers and weekly by the executive team. Telephonic Monitoring (formerly Face-to-Face) Visits Options Counseling provide to the member: Since the IPOC was not completed during the NJ Choice Assessment suspension, the SCS documentation template was revised to include option counseling results and CMs were instructed to paste the template in the Summary statement of the SCS tool. Participant direction options were added to the templates. The Cost Neutrality analysis is included in the Plan of Care and the CMs are directed to complete on all MLTSS members. Initial POC and Back-up Plan: A Combo report has been developed to monitor the enrollment date and the date the Plan of Care is due to ensure the POC is completed by day 45. This report is monitored daily by the managers and weekly by the executive team. The POC was completely revised, trained, and implemented during Q1 2022. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. During the training, timeframes for completion of the POC were reinforced additional training completed in April and June 2022 to reinforce SMART goal and intervention development. Audits are completed quarterly to review the POC to ensure person-centered approach. Reporting for adherence to required timeframes is run daily and provided to the management team.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Risk Assessment and Risk Management Agreement are completed initially, annually, and change in condition. Required documentation of the Back-Up Plan was put in the revised Plan of Care that was rolled-out in March 2022. Member Rights and Responsibilities: Includes the process for grievance/appeals and how to report a Critical Incident. The Member Rights and Responsibilities is signed by the member initially and annually. Additional documentation is in the Plan of Care. Ongoing Care Management The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. There is a designated team that reviews discharges from facilities via the Blended Census Reporting Tool to notify CM of recent Discharge from an institution. CM calls the member within 10 days of discharge to confirm services have resumed and no other services are needed. Will schedule a face-to-face visit for any change in condition as a result of the hospitalization.	
UHCCP should address the deficiencies noted in the MLTSS - NF 2021 CM Review for scores below 86%.	Facility Plan of Care: The Facility Plan of Care metric was added to the revised Plan of Care during Q1 2022 to serve as a reminder to the CM to obtain and upload to the electronic record. Initial Plan of Care and Ongoing Plans of Care (addresses PM 8, 9, 11) The POC was completely revised, trained, and implemented during Q1 2022. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. During the training, timeframes for completion of the POC were reinforced. Additional training completed in April and June 2022 to reinforce SMART goal and intervention development. Audits are completed quarterly to review the POC to ensure person-centered approach. Reporting for adherence to required timeframes is run daily and provided to the management team. Informal and Formal supports are required documentation elements in the 2022 revised POC and includes a summary of how those services benefit the member. Documentation of the Member's agreement/disagreement with the POC statements is in the last section of the Plan of Care. It is completed by the member or their authorized representative. Transition Planning CMs completed telephonic outreach facilities to obtain an update on the member since many members do not have telephones in their rooms. However, with the re-opening of the facilities, the CMs evaluate the member transfer to the community and options counseling is completed. The CMs request the date for the IDT at the facility; however, not all facilities notify the CM of the date. This is an issue the managers are reviewing with the NF leadership. All potential discharge IDTs are attended by the CM and the Nursing Home Transition team to ensure safe discharge plan is developed and	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	implemented. The minutes from these meetings are documented in the member chart. Most of the members who have discharged from the facility have had an IDT. Out of the 112 members referred to the Transition Team, 70% of those members had at least 1 IDT. The other 30% are pending discharge and will have an IDT before discharge. There were less than 5 members that left without HP prior notification. Timely onsite review of the member is monitored through the Combo report for adherence to required timeframes is run daily and provided to the management team. The POC was revised to have a place for documentation of the payment liability and review of placement and services and is completed with the initial POC development and reviewed annually. Reassessment of the POC and Critical Incident Reporting (Addresses PM 18) CMs review with the Member and/or representative on how to report a Critical Incident as they review the Member Rights and Responsibilities handbook during the initial visit and annually. The Member Rights and Responsibilities includes the process for grievance/appeals and how to report a Critical Incident. This is signed by the member/representative and documented on the POC. The NJCA is completed on members who have had a significant change in condition once they are notified by the facility or notified of a recent hospitalization discharge. The NJCA is also completed prior to discharge from the facility. The Combo Report was developed to provide the managers with oversight to the adherence to required timeframes and is run daily and provided to the management team.	

[1] **Addressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2023.

WCHP Response to Previous EQR Recommendations

Table 54 displays WCHP's progress related to the *State of New Jersey DMAHS, WellCare Health Plans of New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of WCHP's response.

Table 54: WCHP Response to Previous EQR Recommendations

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
WellCare should address the PIP validation elements that were determined to be not met or partially met.	WellCare Health Plan implemented activities to define specific data monitoring with clarification to impact performance outcomes. PIP Topic: Medicaid Primary Care Physician Access and Availability, the specific data monitored has been clarified with respect to cohorts and Performance Indicators (#3 and #4). The intervention tracking measure #3, data collection and distribution to the PCP providers to identify any true impact regarding utilization of primary care services has been addressed and clarified. The MCO ensured that all ITM's tracking (monthly, quarterly, bi-annually or annually) has been updated in the August submission. The provider tracking log and its	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	purpose was discussed. The MCO clarified the specifics regarding distribution to providers in the cohort and the alignment with the Barrier Analysis to understand the impact of the intervention over the life of the PIP. The MCO updated the Change Table to reflect any changes and date of inclusion into the PIP. Following the first year of interventions, the health plan evaluated the interventions and performed a quantitative and qualitative analysis. Passive interventions were either terminated or enhanced to include a more active approach. Intervention Tracking Measures (ITM's) were enhanced to include specifics regarding data collection as well as methods of distribution to provider to realize any true impact of the PCP services. Appendix D: NYU ER Algorithm was included in subsequent submissions. The impact of COVID-19 was also considered and tracked to show data as the situation is evolving. Outreach to cohort to learn about Access and Availability returning to pre-Covid times was also addressed for those who need alternate days/hours.	
The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Adult Social Day Care.	The Plan's recruitment efforts continue with concentration on "true" deficiencies (no servicing providers in county) available in Cape May, Hunterdon, Salem, Sussex, and Warren County. WellCare will continue to use providers in bordering counties to address needs. As an Immediate measure, WellCare has identified Senior Centers in the counties that services. The Plan will use the list of Senior Centers as a resource to link members to services in their communities. WellCare will continue to recruit providers as they become available.	Addressed
The MCO should continue to focus on improving after-hours availability for Adult PCP and Specialists (Oncology).	The Plan continues to focus on improving after hours availability. In response to the survey, on 2/10/2022 the Network Team obtained a list provider who failed the After-Hours survey and conducted outreach and education. As a process enhancement, the tracking tool was moved to a central location that will allow each Network representative to review and update accordingly. In addition, the plan began outreaching failed providers regarding after-hours deficiency on 3/11/2022 and educated these providers on our access standards. As reinforcement, an Access & Availability flyer specific to their specialty was provided via email or fax. After-hours access standards for PCP's, Specialists and OB-GYN providers are also in the Provider Manual. This is a continued intervention. For 2022 the plan added a new intervention to follow-up with the providers within 90 days after the initial outreach to ensure that the reason they failed has been corrected.	Addressed
The MCO should implement a process to ensure that all MLTSS Member Appeal letters are sent to the appropriate Member, and all determination letters should be	Appeals Management utilizes the Closed Summary Report, weekly, to monitor the compliance of all appeals processed by the team including member letters to review accuracy. Appeals Management utilizes the Appeals Inventory Report daily (2 times per day) at the start of the day and mid-point to ensure timely processing of cases. The appeals team has outlined huddles 3 times per day to discuss assignments, the reports mentioned above, barriers or concerns. Appeals Management also monitors EVP metrics monthly to determine the compliance status of all appeals including acknowledgement letters as well as determination letters and the compliance. Table 3A is reviewed weekly to monitor for timeliness of letters and compliance with TAT. This report reflects the status of all	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
sent out in timely manner.	appeals in the last quarter including MLTSS Member Letters. All member letters are tracked and reviewed by daily by the Appeals Supervisor before sending to the member. The management team hired 5 new associates for appeals associates (3 FTEs and 2 Temps) from March 2022 thru June 2022 to improve compliance and TAT.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	WellCare's goal is to increase HEDIS ® rates to the NCQA 50th percentile or higher. Plan submits on an annual basis, a quality work plan as per contract and State/IPRO request where clinical performance fell below the NCQA 50th percentile. Planned and ongoing interventions include: 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. Quality team coordinate efforts to close care gaps, educate providers on the importance of closing care gaps, and assists the provider with care gap reports and missed opportunities, this process includes reviewing a medical record to identify coding deficiencies then re-educating providers/practice manager WellCare also provides a laminated coding sheet with the current codes for the billing staff to ensure claims are processed accurately and timely. WellCare leadership and Quality team monitor visits monthly via QI metric reports. WellCare Preventive Service Outreach (PSO) program to make outbound calls to non-compliant members for various Medicaid measures notifying/educating them 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. NJ QI Performance Improvement Team (PIT) Work Group - Weekly Team Meeting to discuss tracking of projects, rate, progress on measures, programs/initiatives, possible community outreach by health educator for focused HEDIS measures. This meeting invite is extended to cross-functional departments within the organization for collaboration on quality initiatives.	Addressed
The MCO should ensure that all reporting include all appropriate MLTSS members to comply with EQRO Performance Measure validation.	WellCare's Reporting and Analytics team works closely with the Shared Services IT department to run reporting that meets specifications for measures as outlined by the criteria received each fiscal year from the MAHS department. The plan includes MLTSS member level detail data for analysis purposes, which additionally allows the department to confirm MLTSS members are appropriately included in the measure. The validation process of each measure is conducted through multiple steps which include review by the market's Reporting and Analytics team and Clinical Operations team. Depending on the measure, additional review is done through the care management database to confirm events such as NF to HCBS transitions.	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	The plan implemented a tracking mechanism which documents receipt date of output file, staff processing/analysis of the data and preparation of the summary. Once a summary is written, the Manager of Medical Management reviews the summary and data. A final review is done by the director of Clinical Ops, BH and/or MLTSS as needed and tracked prior to the final submission. Within each step, comments are documented and tracked, and any updates or edits required are referred back to the preparer. Final submission of Performance Measures is done via email to MAHS and designated state partners as well as the plan's Regulatory Affairs team. Final results reported for each measure are tracked on a separate tracking document where the plan reviews trends identified and results are shared with Medical Management leadership, MLTSS Care Management teams as well as the plan's quarterly UMAC meetings.	
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	WellCare's goal is to increase Adult and Child CAHPS scores to the NCQA 50th percentile or higher. The work plan is divided into categories for each CAHPS measure that was identified as not meeting the 50th percentile. Categories include: CAHPS Measure, Current and Previous year rate, Barriers, Interventions, Goals, Monitoring Plan, Responsible Party List, and Updates which include progress metrics toward goals. Planned and ongoing interventions: WellCare of New Jersey has established a monitoring process (CAHPS Customer Service calls) in which recorded customer services calls are analyzed and training opportunities for Customer Service rep are identified. Goal is to improve the quality of care provided to members during inbound customer service calls. WellCare of New Jersey collects data and identifies opportunities of improvement by reviewing all Surveys including the Provider Satisfaction Survey results to help create actionable interventions. Quality Team visits to targeted groups/practitioners for education regarding use of the Provider Portal, Specialist in network, Access, and Availability standards. This information was distributed to practitioners within the network by the Quality Practice Advisors and Provider Relations teams. The Quality Provider toolkit is an easy-to-understand education resource that displays HEDIS, CAHPS/HOS and Quality standards in a nicely packaged, colorful folder for practitioners and their staff to reference. In addition, the document, titled "Coordination of Care" is also included in the Provider toolkit. Phone numbers for Customer Service, Care Management and Community Connection are shared with practitioners and staff to strengthen partnership for member care. The CAHPS workgroups to meet regularly and on an ad hoc basis to track the Medicaid CAHPS work plan to discuss progress and outcomes.	Addressed
WCHP should address the deficiencies noted in the following areas: • GP - All CM element specific deficiencies	To address the deficiencies noted in the review for the GP population, the Plan is meeting with the Eliza Vendor to discuss their aggressive outreach process for Initial Health Screening (IHS) completion within 45 days of enrollment. The Plan is collaborating with Eliza to determine additional interventions that will increase their success rate such as adding WellCare Health Plans to the Caller ID rather than it being an 800 number. In addition, the Plan has determined viability of all Eliza outreach attempts to be documented into the CM documentation system rather than a monthly report. Management will continue to monitor the timeliness for completion	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
noted in the review.	of the CNA and the care plans via the Non-LTSS CM Report. All CMs are notified via email of any cases not in compliance. Timeliness metrics were added to the report in October 2021. DDD Supervisor will continue to monitor the monthly score card to ensure timeliness of CNA completion for all newly enrolled DDD members. DDD supervisor is responsible for auditing all new members every 45 days to determine compliance with assessment and care plan completion.	
WCHP should address the deficiencies noted in the following areas: • DDD – Preventive Services, and all CM element specific deficiencies noted in the review.	The Plan is addressing the deficiencies for the DDD – Preventive Services by conducting monthly meetings with dental vendor (Liberty Dental) to continue call and text campaign for DDD members. The monthly preventive non-compliant DDD member report is sent to CM team for targeted CM outreach to educate and coordinate visits to close preventative gaps. The CM team targeted mailing of dental educational material to DDD members and calls to assist with scheduling. The plan is exploring opportunities for a texting campaign reminder for all vaccines for DDD members and all pediatric population. The CMs is to continue to pull vaccine record from the state Immunization Registry, NJIIS, to create immunization problem on the care plan for tracking. Pull HEDIS records on kids with no vaccinations on record to determine accuracy of the no claims files. All pediatric providers received the 2021 Periodicity Table and the Provider Score Card that includes the percentage of vaccinated members monthly or bimonthly and all providers received care gaps and rates quarterly with the Provider Profiling reports. The CM and Quality Team implemented a performance improvement plan, over the next 3 years, to target those members unvaccinated between the ages of 0 and 30 months. The proposal was submitted and approved by the state. The Dental vendor to continue call campaign for DDD/DCPP members to encourage utilization of their dental benefits, schedule appointments and assist with transportation. The Vendor started telephonic outreach to those members that did not have a claim in 2020 but had a dental claim in 2019. That total population will be the 2021 focus for (vendor) Liberty Dental and CM because we are aware that those members have had a history of dental care. The goal is to ensure that all members have a known dental home via liberty dental report and identify the top 3 dentists with a high volume of poor preventative outcomes to follow up with their assigned members for appointments.	Addressed
WCHP should address the deficiencies noted in the following areas: • DCP&P-Preventive Services, and all CM element specific deficiencies noted in the review.	The Plan is addressing the deficiencies noted in the DCP&P Preventive services via the following actions: Explore opportunities for a texting campaign reminder for all vaccines for DCPP members and all pediatric population. CM to continue to pull vaccine record from the state Immunization Registry, NJIIS, to create immunization problem on the care plan for tracking. Explore opportunities for a texting campaign reminder for all vaccines for DCPP members and all pediatric population. CMs to continue to pull vaccine record from the state Immunization Registry, NJIIS to create immunization problem on the care plan for tracking. Pull HEDIS records on kids with no vaccinations on record to determine accuracy of the no claims files.	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	All pediatric providers will receive the 2021 Periodicity Table and the Provider Score Card that includes the percentage of vaccinated members monthly or bimonthly and all providers receive care gaps and rates quarterly with the Provider Profiling reports. CM and Quality Team will be implementing a performance improvement plan over the next 3 years to target those members unvaccinated between the ages of 0 and 30 months. Proposal was submitted and approved. Dental vendor to continue call campaign for DDD/DCPP members to encourage utilization of their dental benefits, schedule appointments and assist with transportation. Vendor started telephonic outreach to those members that did not have a claim in 2020 but had a dental claim in 2019. That total population will be the 2021 focus for (vendor) Liberty Dental and CM because we are aware that those members have had a history of dental care. Ensure that all members have a known dental home via liberty dental report and identify the top 3 dentists with a high volume of poor preventative outcomes to follow up with their assigned members for appointments.	
WCHP should address the deficiencies noted in the MLTSS – HCBS 2021 CM Review for elements that scored below 86%.	The following is a summary of actions that were taken for the areas that scored below 86% in the MLTSS HCBS 2021 Review: All MLTSS Care Managers have been re-educated on areas that scored below 86%. An annual IRR MLTSS Competency to assess the care manager' s knowledge of the MLTSS program is in use. Continued 1:1 case conference between Care Manager and Manager/Supervisor with focus on areas of deficiency. New MLTSS care Managers (employed for less than 3 months) are required to submit all Plans of Care to their Manager/Supervisor until their Manager/Supervisor is satisfied with the plan of care quality. Member record audits are performed monthly by WellCare's Audit Team. Results are shared with management team and are used as a tool for staff education. Mandatory CMS training on PCT (Person Centered Training) is given to all staff. Various Reports (Visit Report, Backup Plan Report, Risk Assessment Report, In-Patient Report) including a Dashboard is in use by management team to increase monitoring of all areas. Monthly Team meetings include presentation of a members' plan of care to promote discussion and to ensure a member-centric approach.	Addressed
WCHP should address the deficiencies noted in the MLTSS - NF 2021 CM Review for elements that scored below 86%.	The following is a summary of actions that were taken for the areas that scored below 86% in the MLTSS NF 2021 Review: All MLTSS Care Managers have been re-educated on areas that scored below 86%. Member record audits are performed monthly by WellCare's Audit Team. Results are shared with management team and are used as a tool for staff education. In addition to WellCare's monthly shared services audit, the Manager of Medical Management Auditing is auditing NF member records focusing specifically on the deficient areas on the NF audit. from the facility Plan of Care. Results will be tracked and trended by team/Care Manager. Care	Addressed

Recommendation for WCHP	WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Managers not meeting these standards will be re-educated/counseled as needed. An annual IRR MLTSS Competency to assess the care manager' s knowledge of the MLTSS program is in use. Continued 1:1 case conference between Care Manager and Manager/Supervisor with focus on areas of deficiency. New MLTSS care Managers (employed for less than 3 months) are required to submit all Plans of Care to their Manager/Supervisor until their Manager/Supervisor is satisfied with the plan of care quality. Mandatory CMS training on PCT (Person Centered Training) is given to all staff. Monthly Team Meetings have presentation of 1-2 member's plan of care to promote discussion and ensure a member-centric approach.	

[1] **Addressed**: MCO's quality improvement (QI) CAP response addressed deficiency, IPRO will monitor implementation in CY 2023.

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

Tables 55–59 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 Measurement Year (MY) 2022 EQR activities as they relate to **quality**, **timeliness**, and **access**.

ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 55: ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2022 PIPs	Five (5) PIPs performed above the 85% for Core Medicaid and 86% for MLTSS thresholds indicating high performance.	ABHNJ – Overall, ABHNJ was compliant in presentation of data and analysis of results although should be mindful to review all calculation prior to submitting PIP reports.
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 73% to 75% did not meet compliance. Those measures were: Availability of services (75%) Coordination and continuity of Care (73%)
HEDIS MY 2021 Performance Measures	ABHNJ reported significant improvements (a more than five percentage point change is considered a significant change) in performance for 12 HEDIS measures.	ABHNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for eight (8) HEDIS measures. All measures are reportable for ABHNJ with the exception of the AMB measure for Duals, Disabled, Other Low Income.
Quality of Care Surveys – Member (CAHPS 2022)	One (1) of eight (8) Adult CAHPS measures was above the 75th percentile.	Seven (7) of eight (8) CAHPS measures for both Adult and Child surveys fell below the 50th percentile.
Core Medicaid - 2022 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, ABHNJ scored over the 85% threshold in 6 categories ranging from 91% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, ABHNJ scored below the 85% threshold in 7 categories ranging from 38% to 73%.
MLTSS – 2022 HCBS CM Review	Of the 6 categories at the sub-population level, ABHNJ scored at or above 86% for 6 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, ABHNJ scored below 86% for 9 of the 15 sub-populations scores.
MLTSS – 2022 NF CM Review	Of the 20 elements for which sufficient denominators were observed ABHNJ scored at or above 86% for 14 elements.	Of the 20 elements for which sufficient denominators were observed, ABHNJ had six (6) review elements that scored below 86%.
Recommendations		
2022 PIPs	No recommendations.	
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4e. The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties. 2. A7. The MCO should focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers, as well as improve after-hours availability. **Programs for the Elderly and Disabled**	

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. ED2. The plan should develop reporting that tracks grievances for the Elderly and Disabled and MLTSS sub populations. **Credentialing and Recredentialing** 1. CR8. The MCO should ensure the review of quality metrics, including a review of complaints/quality issues, performance indicators, UM statistics or enrollee satisfaction surveys at the time of recredentialing.
HEDIS MY 2021 Performance Measures	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.
Quality of Care Surveys – Member (CAHPS 2022)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2022 CM Review	ABHNJ should address the deficiencies noted in the following areas: **GP – Identification, Continuity of Care, Coordination of Services** 1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed. 2. CM3: ABHNJ should ensure that appropriate Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a Care Manager, and that enrollees are identified by the MCO as having potential care management needs, (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management). 3. CM6: ABHNJ should ensure that the IHS is completed within 45 days of enrollment (applies to new Enrollees only) and that when the initial outreach for the IHS is unsuccessful, aggressive outreach attempts are documented and are done within 45 days of the Enrollees enrollment (applies to new enrollees only). 4. CM7: ABHNJ should ensure that the initial outreach to complete the CNA is done and a CNA is completed for the enrollee, and that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment. 5. CM14: ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, aggressive outreach attempts are documented to confirm EPSDT status, and the Care Manager sends EPSDT reminders, Enrollee's immunizations are up to date for Enrollees aged 0-18. The Care Manager should ensure that the immunization status is confirmed by a reliable source, appropriate vaccines are administered for Enrollees aged 18 and above and aggressive outreach attempts are documented to confirm immunization status for Enrollees aged 18 and above; dental needs are addressed for Enrollees aged 21 and above and a dental visit occurred during the review period, that the Care Manager makes attempts to obtain dental status for Enrollees aged 1-21 and those Dental reminders are sent to Enrollees aged 1 to 21. The Care Manager should ensure that Enrollees aged 9 months to 26 months are tested twice for lead and that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test. 6. CM19: ABHNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD). **DDD – Preventive Services, Continuity of Care, Coordination of Services** 1.CM7: ABHNJ should ensure that Comprehensive Needs Assessment (CNA) is done and includes all required elements and that a CNA is completed timely (within 45 days of the Enrollee's enrollment).

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	2. CM14: ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, appropriate vaccines have been administered for Enrollees aged 18 and above and that aggressive outreach attempts were documented to confirm immunization status age 18 and above; the Case Manager should ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21. **DCP&P – Preventive Services** 1.CM7: ABHNJ Comprehensive Needs Assessment (CNA) is done and includes all required elements, and the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment). 2.CM14: ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source and that the Care Manager sends EPSDT reminders; a dental visit occurred during the review period for Enrollees aged 1 to 21 and the Care Manager make attempts to obtain dental status for Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months were tested twice for lead, and the Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
MLTSS – 2022 HCBS CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B.**
MLTSS – 2022 NF CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B**.

AGNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 56: AGNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2022 PIPs	Out of six (6) PIPs scored, two (2) PIPs performed above the 85% for Core Medicaid and 86% for MLTSS thresholds indicating high performance.	AGNJ – Overall, AGNJ was partially compliant in presentation of data and analysis of results. There are opportunities for improvement in establishing performance indicators are clearly defined and measurable and corresponds with goals.
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 64% to 67% did not meet compliance. Those measures were: Availability of services (67%) Coordination and continuity of Care (64%);
HEDIS MY 2021 Performance Measures	AGNJ reported significant improvements (a more than five percentage point change is considered a significant change) for five (5) HEDIS measures.	AGNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for 10 HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2022)	One (1) of eight (8) Adult CAHPS measures was above the 75%.	Four (4) of eight (8) Adult CAHPS measures fell below the 50th percentile. Seven (7) of eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2022 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, AGNJ scored over the	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, AGNJ scored below

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
	85% threshold in six (6) categories ranging from 90% to 100%.	the 85% threshold in seven (7) categories ranging from 29% to 81%.
MLTSS – 2022 HCBS CM Review	Of the 6 categories at the sub-population level, AGNJ scored at or above 86% for 10 of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, AGNJ scored below 86% for 5 of the 15 sub-populations scores
MLTSS – 2022 NF CM Review	Of the 20 elements for which sufficient denominators were observed AGNJ scored at or above 86% for 15 elements.	Of the 20 elements for which sufficient denominators were observed, AGNJ had five (5) review elements that scored below 86%.
Recommendations		
2022 PIPs	AGNJ should address the PIP validation elements that were determined to be not met or partially met.	
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4a. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County. 2. A4b. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Warren County. 3. A4e. The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties. 4. A7. The MCO should focus on improving appointment availability for OB-GYNs, Other Specialists, Urgent Specialty care, Behavioral Health Prescribers, Behavioral Health Non-Prescribers as well as after-hours non-compliance. **Committee Structure** 1. CS6. The MCO should ensure the Community/Health Education Advisory Committee is held quarterly and evidence of the meeting is documented. 2. CS8. The MCO should ensure the MLTSS Consumer Advisory Committee is held quarterly and evidence of the meeting is documented. **Enrollee Rights and Responsibilities** 1. ER2. The MCO should ensure that policies provided contain all Contract requirements.	
HEDIS MY 2021 Performance Measures	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, AGNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
Quality of Care Surveys – Member (CAHPS 2022)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	
Core Medicaid - 2022 CM Review	AGNJ should address the deficiencies noted in the following areas: **GP – Preventive Services, Continuity of Care** 1. CM2: AGNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed. 2. CM3: AGNJ should ensure that appropriate Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a Care Manager. 3. CM6: AGNJ should ensure that the IHS is completed within 45 days of enrollment (applies to new Enrollees only). 4. CM7: AGNJ should ensure that the initial outreach to complete the CNA is done and a CNA is completed for the enrollee. 5. CM14: AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, aggressive outreach attempts are documented to confirm EPSDT status, and the Care Manager sends EPSDT reminders, Enrollee's	

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	immunizations are up to date for Enrollees aged 0-18, confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status.; immunization status is confirmed by a reliable source, appropriate vaccines are administered for Enrollees aged 18 and above and aggressive outreach attempts are documented to confirm immunization status for Enrollees aged 18 and above. appropriate vaccines are administered for Enrollees aged 18 and above and that aggressive outreach attempts are documented to confirm immunization status; dental needs are addressed for Enrollees aged 21 and above and a dental visit occurred during the review period, that the Care Manager makes attempts to obtain dental status for Enrollees aged 1-21 and those Dental reminders are sent to Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months are tested twice for lead and that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test, that the Care Manager makes attempts to obtain lead status for Enrollees aged 9 months to 72 months and sends lead screening reminders. 6. CM19: AGNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD), and that the Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, discharge planning if hospitalized, pharmacy and other support services as appropriate for the Enrollee and are noted in the Enrollee's case files. **DDD – Preventive Services** 1. CM7: AGNJ should ensure that Comprehensive Needs Assessment (CNA) is done and includes all required elements, and a CNA is completed timely (within 45 days of the Enrollee's enrollment). 2. CM8: AGNJ should ensure that the Care Plan was updated upon a change in the Enrollee's care needs or circumstances. 3. CM14: AGNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source, and that the appropriate vaccines have been administered for Enrollees aged 18 and above; that Enrollees aged 9 months to 26 months were tested twice for lead and the Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test. **DCP&P – Preventive Services** 1. CM14: AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source and the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source; that a dental visit occurred during the review period for Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months were tested twice for lead and Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.
MLTSS – 2022 HCBS CM Review	AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.
MLTSS – 2022 NF CM Review	AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.

HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 57: HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2022 PIPs	Five (5) PIPs performed above the 85% for Core Medicaid and 86% for MLTSS thresholds indicating high performance.	HNJN – Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include a full review of data ensuring data corresponds with interventions ensuring reader clarity and understanding.
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 73% to 83% did not meet compliance. Those measures were: Availability of services (83%) Coordination and continuity of Care (73%);
HEDIS MY 2021 Performance Measures	HNJH reported significant improvements (a more than five percentage point change is considered a significant change) in rates for 12 HEDIS measures.	HNJH reported significant declines (a more than five percentage point change is considered a significant change) in performance for seven (7) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2022)	Two (2) of 8) Adult CAHPS measures were above the 75th percentile.	Five (5) of eight (8) Adult CAHPS measures fell below the 50th percentile. All eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2022 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, HNJH scored over the 85% threshold in five (6) categories ranging from 97% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, HNJH scored below the 85% threshold in eight (8) categories ranging from 57% to 81%.
MLTSS – 2022 HCBS CM Review	Of the 6 categories at the sub-population level, HNJH scored at or above 86% for 15 of the 15 sub-populations scores.	None of the 6 categories at the sub-population level scored below 86%.
MLTSS – 2022 NF CM Review	Of the 20 elements for which sufficient denominators were observed HNJH scored at or above 86% for 15 elements.	Of the 20 elements for which sufficient denominators were observed, HNJH had five (5) review elements that scored below 86%.
Recommendations		
2022 PIPs	No recommendations.	
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4d. The MCO should continue to expand the Dental/Specialty Dental network in Gloucester County. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers. 2. A7. The MCO should focus on improving appointment availability for, adult PCPs, specialists, dental providers, and behavioral health providers, as well as improve after-hours availability. **Credentialing and Recredentialing** 1. CR9.The MCO should ensure every MLTSS provider submits an attestation as evidence for conducting criminal background checks as per Contract requirements.	
HEDIS MY 2021 Performance Measures	The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
Quality of Care Surveys – Member (CAHPS 2022)	The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2022 CM Review	HNJH should address the deficiencies noted in the following areas: **GP – Preventive Services, Continuity of Care, Coordination of Services** 1. CM3: HNJH should ensure that enrollees identified by IPRO as having Potential CM needs during the review period that the MCO did not identify (applied to existing enrollees enrolled prior to 11/16/2020.) 2. CM7: HNJH should ensure that the initial outreach to complete a Comprehensive Needs Assessment is done and completed for the enrollee. 3. CM8: HNJH should ensure that the Care Plans are developed within 30 days of the CNA completion and HNJH should ensure that upon a change in care needs or circumstances, and that the Care Plan is updated. 4. CM14: HNJH should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status and appropriate vaccines have been administered for Enrollees aged 18 and above and aggressive outreach attempts were documented to confirm immunization status for Enrollees; a dental visit occurred during the review period for Enrollees aged 1 to 21, the Care Manager makes attempts to obtain dental status for Enrollees and Dental reminders are sent to Enrollees aged and that Enrollees aged 9 months to 26 months are tested twice for lead, that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test and that Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months and the Care Manager sends lead screening reminders for Enrollees. 5. CM19: HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) and for Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services and the Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee. **DDD – Preventive Services, Continuity of Care** 1. CM7: HNJH should ensure that the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment), the CNA is done and includes all required elements and when the initial outreach is unsuccessful, aggressive outreach attempts are documented and done within 45 days of the Enrollee's enrollment. 2. CM14: HNJH should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status, appropriate vaccines have been administered for Enrollees aged 18 and above a dental visit occurred during the review period for Enrollees aged 1 to 21; and Enrollees aged 9 months to 26 months were tested twice for lead and that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. **DCP&P – Preventive Services, Continuity of Care** 1. CM7: HNJH should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment. 2. CM14: HNJH should ensure that immunizations are up to date for Enrollee's aged 0-18, confirmed by a reliable source and aggressive outreach attempts are documented to confirm

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
	immunization status; a dental visit occurred during review period for Enrollee's aged 1-21; and Enrollees aged 9-26 months are tested twice for lead, and that Enrollees who have never previously been tested for lead before 24 months of age received a blood test.
MLTSS – 2022 HCBS CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D.**
MLTSS – 2022 NF CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D**.

UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 58: UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2022 PIPs	Four (4) of five (5) PIPs performed above the 85% for Core Medicaid and 86% for MLTSS thresholds indicating high performance.	UHCCP – Overall, UHCCP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions.
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 64% to 67% did not meet compliance. Those measures were: Availability of services (67%) Coordination and continuity of Care (64%);
HEDIS MY 2021 Performance Measures	UHCCP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for six (6) HEDIS measures.	UHCCP reported significant declines (a more than five percentage point change is considered a significant change) in rates for four (4) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2022)	One (1) of eight (8) Adult CAHPS measures was above the 75th percentile. One (1) Child CAHPS measure was above the 75th percentile.	Seven (7) of eight (8) for both the Adult CAHPS and Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2022 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, UHCCP scored over the 85% threshold in five (5) categories all at 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, UHCCP scored below the 85% threshold in eight (8) categories ranging from 42% to 83%.
MLTSS – 2022 HCBS CM Review	Of the 6 categories at the sub-population level, UHCCP scored at or above 86% for one (1) of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, UHCCP scored below 86% for 14 of the 15 sub-populations scores.
MLTSS – 2022 NF CM Review	Of the 20 elements for which sufficient denominators were observed UHCCP scored at or above 86% for three (3) elements.	Of the 20 elements for which sufficient denominators were observed, UHCCP had 17 review elements that scored below 86%.
Recommendations		
2022 PIPs	UHCCP should address the PIP validation elements that were determined to be not met or partially met.	
2022 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4d. The MCO should continue to expand the Dental/Specialty Dental network in Atlantic, Cumberland and Morris Counties. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers.	

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
*(*July 1, 2021 to June 30, 2022*)*	2. A4e. The MCO should continue to address hospital deficiencies in Atlantic and Cumberland Counties. 3. A4f. The MCO should continue to expand the MLTSS network to include at least two providers in every County for Medical Day Care. **4.** A7. The MCO should focus on improving appointment availability for OB/GYN, High Volume Specialist, and Behavioral Health providers, as well as improve after-hours availability. **Programs for the Elderly and Disabled** 1. ED8. Quality Program Evaluation looks at performance by age band. Many of the measures are relevant to the Elderly and Disabled population. However, in their analyses of performance, the plan does not focus on these measures with regard to the Elderly and Disabled population. The plan should develop an analysis plan that focuses on assessment of quality measures for the Elderly and Disabled and MLTSS populations. **Provider Training and Performance** 1. PT3. The MCO should initiate a system for monitoring providers for compliance with state and federal laws and regulations concerning family planning services for minors.
HEDIS MY 2021 Performance Measures	Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS 2022)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2022 CM Review	UHCCP should address the deficiencies noted in the following areas: **GP – Preventive Services, Continuity of Care** 1. CM2: UHCCP should ensure that adequate discharge planning is performed for Enrollees who are hospitalized. 2. CM3: UHCCP should ensure that Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020), and that requested Policies and Procedures are submitted in a timely manner. 3. CM6: UHCCP should ensure that requested documents and documentations are submitted in a timely manner. 4. CM7: UHCCP should ensure that initial outreaches to complete a CNA is done and that a level of Care Management is determined for the Enrollee. 5. CM8: UHCCP should ensure that the Care Plan is developed within 30 days of CNA Completion. 6. CM13: UHCCP should ensure that requested documentation is submitted in a timely manner. 7. CM14: UHCCP shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts were documented to confirm immunization status, that appropriate vaccines have been administered for Enrollees aged 18 and above and that aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above; that dental needs are addressed for Enrollees aged 21 and above and ensure that attempts are made to obtain dental status for Enrollees aged 1 to 21, and a dental visit occurred during the review period for Enrollees aged 1 to 21 and ensure that dental reminders were sent to Enrollees aged 1 to 21; and Enrollees aged 9 months to 26 months were tested twice for lead, Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test and that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months and ensure that the Care Manager makes attempts to obtain lead status for Enrollees aged 9 months to 72 months.

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	8. CM19: UHCCP shall ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD). **DDD – Preventive Services, Continuity of Care** 1. CM7: UHCCP should ensure that a CNA is completed with all required components timely within 45 days of enrollment. 2. CM13: UHCCP should ensure that requested documents and documentations are submitted in a timely manner. 3. CM14: UHCCP shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source and ensure that appropriate vaccines have been administered for Enrollees aged 18 and above. **DCP&P- Preventive Services** 1. CM7: UHCCP should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and are completed within 45 days of the Enrollee's enrollment and that requested documents and documentations are submitted in a timely manner. 2. CM13: UHCCP should ensure that requested documents and documentations are submitted in a timely manner. 3. CM14: UHCCP shall ensure that aggressive outreach attempts were documented to confirm immunization status; a dental visit occurred during the review period for Enrollees aged 1 to 21; that Enrollees aged 9 months to 26 months were tested twice for lead and Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
MLTSS – 2022 HCBS CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E.**
MLTSS – 2022 NF CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E**.

WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 59: WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations

WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2022 PIPs	Three (3) of five (5) PIPs performed above the 85% for Core Medicaid and 86% for MLTSS thresholds indicating high performance.	WCHP – Overall, WCHP was partially compliant in presentation of data and analysis of results. Opportunities for improvement exist in establishing robust interventions. There are also opportunities for improvement in the consistent presentation of Intervention Tracking Measures (ITMs) throughout the life cycle of the PIPs.
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Two (2) standards, ranging from 73% to 75% did not meet compliance. Those measures were: Availability of services (75%) Coordination and continuity of Care (73%);
HEDIS MY 2021 Performance Measures	WCHP reported significant improvements (a more than five percentage point change is	WCHP reported significant declines (a more than five percentage point change is

WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
	considered a significant change) in rates for nine (9) HEDIS measures.	considered a significant change) in rates for eight (8) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2022)	Seven (7) of eight (8) Adult CAHPS measures were above the 50th percentile.	One (1) of eight (8) Adult CAHPS measures fell below the 50th percentile. Seven (7) of eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2022 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, WCHP scored over the 85% threshold in five (5) categories ranging from 91% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, WCHP scored below the 85% threshold in eight (8) categories ranging from 35% to 82%.
MLTSS – 2022 HCBS CM Review	Of the 6 categories at the sub-population level, WCHP scored at or above 86% for six (6) of the 15 sub-populations scores.	Of the 6 categories at the sub-population level, WCHP scored below 86% for nine (9) of the 15 sub-populations scores.
MLTSS – 2022 NF CM Review	Of the 19 elements for which sufficient denominators were observed WCHP scored at or above 86% for two (2) elements.	Of the 19 elements for which sufficient denominators were observed, WCHP had 17 review elements that scored below 86%.
Recommendations		
2022 PIPs	WellCare should address the PIP validation elements that were determined to be not met or partially met.	
2022 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2021 to June 30, 2022*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4b. The MCO should continue to negotiate a contract with pediatric providers in Atlantic County. 2. A4f. The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Assisted Living and Medical Day Care. 3. A7. The MCO should continue to focus on improving after-hours availability. **Credentialing and Recredentialing** 1. CR9. The MCO should ensure MLTSS providers submit an attestation as evidence for conducting criminal background checks as per Contract requirements. **Administration and Operations** 1. AO3. The MCO should develop procedures and reports to monitor the training of new hire orientation along with retraining of current Member Services representatives when deficiencies are identified.	
HEDIS MY 2021 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
Quality of Care Surveys – Member (CAHPS 2022)	The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	
Core Medicaid - 2022 CM Review	WCHP should address the deficiencies noted in the following areas: **GP - Preventive Services, Continuity of Care** 1. CM2: WellCare should ensure for GP Enrollees who are hospitalized, that adequate discharge planning is performed. 2. CM3: WellCare should ensure that Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) and the Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) as well as the Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020).	

WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	3. CM6: WellCare should ensure that an IHS is completed within 45 days of enrollment for new General Population Enrollees and aggressive outreach should be attempted and documented when initial outreach is unsuccessful within 45 days of the Enrollee's enrollment (applies to new Enrollees only). 4. CM7: WellCare should ensure that initial outreach to complete a CNA is done timely and ensure that the Comprehensive Needs Assessment be completed for all applicable Enrollees. 5. CM14: WellCare should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm EPSDT status, and the Care Manager sent EPSDT reminders, Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm immunization status and appropriate vaccines have been administered for Enrollees aged 18 and above and that aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above; dental needs are addressed for Enrollees aged 21 and above, that a dental visit occurred during the review period for Enrollees aged 1 to 21 and that dental reminders were sent to Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months were tested twice for lead, enrollees who had never previously been tested for lead before 24 months of age received a blood lead test and that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. 6. CM19: WellCare shall ensure that the Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)documentation of all contacts and linkages to medical and other services in are in the Enrollee's case files. **DDD – Preventive Services** 1. CM2: WellCare should ensure for DDD Enrollees who are hospitalized, that adequate discharge planning is performed. 2. CM7: WellCare should ensure that a level of Care Management is determined for the Enrollee. 3. CM14: WellCare shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source and that aggressive outreach attempts are documented to confirm immunization status and appropriate vaccines have been administered for Enrollees aged 18 and above; a dental visit occurred during the review period for Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months were tested twice for lead. **DCP&P- Preventive Services** 1. CM7: WellCare should ensure that the outreach for the CNA was timely within 45 days of the Enrollee's enrollment and ensure the completion of the CNA was timely within 45 days of enrollment. 2. CM14: WellCare shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source; a dental visit occurred during the review period for Enrollees aged 1 to 21; Enrollees aged 9 months to 26 months were tested twice for lead and Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
MLTSS – 2022 HCBS CM Review	WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F.**
MLTSS – 2022 NF CM Review	WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.

Appendix A: January 2022 – December 2022 NJ MCO-Specific Review Finding

Note: This is a separate document.

Appendix B: ABHNJ 2022 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix C: AGNJ 2022 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix D: HNJH 2022 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix E: UHCCP 2022 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix F: WCHP 2022 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix G: Supplemental Documents – Submission Guides for 2022 Annual Assessment Review and 2022 Care Management Audits (Core Medicaid and MLTSS)

Note: This is a separate document.

APPENDIX A: January 2022–December 2022 MCO-Specific Review Findings (2022 – 2023 Reporting Cycle)

Appendix Table of Contents

APPENDIX A: JANUARY 2022–DECEMBER 2022 MCO-SPECIFIC REVIEW FINDINGS (2022 – 2023 REPORTING CYCLE) 1

ABHNJ CORE MEDICAID/MLTSS ANNUAL ASSESSMENT OF MCO OPERATIONS 3

ABHNJ 2022 Annual Assessment of MCO Operations 3

ABHNJ PERFORMANCE IMPROVEMENT PROJECTS 4

ABHNJ PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative 4
ABHNJ PIP 2: Improving Access and Availability to Primary Care for the Medicaid Population 7
ABHNJ PIP 3: Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations 11
ABHNJ PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management 14
ABHNJ PIP 5: Improving Coordination of Care and Ambulatory Follow up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations 19

ABHNJ – HEDIS AUDIT REVIEW TABLE MY 2021 23

AGNJ CORE MEDICAID/MLTSS ANNUAL ASSESSMENT OF MCO OPERATIONS 30

AGNJ 2022 Annual Assessment of MCO Operations 30

AGNJ PERFORMANCE IMPROVEMENT PROJECTS 31

AGNJ PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative 31
AGNJ PIP 2: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members 35
AGNJ PIP 3: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months 39
AGNJ PIP 4: Decreasing Gaps in Care in Managed Long Term Services and Supports 42
AGNJ PIP 5: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population 47
AGNJ PIP 6: Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population 51

AGNJ – HEDIS AUDIT REVIEW TABLE MY 2021 55

HNJH CORE MEDICAID/MLTSS ANNUAL ASSESSMENT OF MCO OPERATIONS 62

HNJH 2022 Annual Assessment of MCO Operations 62

HNJH PERFORMANCE IMPROVEMENT PROJECTS 63

HNJH PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative 63
HNJH PIP 2: Increasing PCP Access and Availability for Members with Low Acuity, Non-Emergent ED visits 66
HNJH PIP 3: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population 70
HNJH PIP 4: Reducing admissions, readmissions and gaps in services for members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population 74
HNJH PIP 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations 77

HNJH – HEDIS AUDIT REVIEW TABLE MY 2021 81

UHCCP CORE MEDICAID/MLTSS ANNUAL ASSESSMENT OF MCO OPERATIONS 91

UHCCP 2022 Annual Assessment of MCO Operations 91

UHCCP PERFORMANCE IMPROVEMENT PROJECTS 92

UHCCP PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative 92
UHCCP PIP 2: Decrease Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical) 96
UHCCP PIP 3: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations 99

UHCCP PIP 4: Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population 103
UHCCP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations 107

UHCCP – HEDIS AUDIT REVIEW TABLE MY 2021 110

WCHP CORE MEDICAID/MLTSS ANNUAL ASSESSMENT OF MCO OPERATIONS 118

WCHP 2022 Annual Assessment of MCO Operations 118

WCHP PERFORMANCE IMPROVEMENT PROJECTS 119

WCHP PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative 119
WCHP PIP 2: Medicaid Primary Care Physician Access and Availability 123
WCHP PIP 3: Improving Early and Periodic Screening diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations 126
WCHP PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis 131
WCHP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations 134

WCHP – HEDIS AUDIT REVIEW TABLE MY 2021 138

ABHNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

ABHNJ 2022 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	25	30	24	24	6**	0	80%	4	1	2
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	5	14	12	12	2	0	86%	2	8	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[5]	21	16	21	18	18	3	0	86%	3	1	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	44	43	43	1	0	98%	0	0	1
Provider Training and Performance	11	11	11	11	11	0	0	100%	0	0	0
Satisfaction	5	5	5	5	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	8	0	0	100%	0	0	0
Credentialing and Re-Credentialing	10	10	10	9	9	1	0	90%	0	0	1
Utilization Management	30	26	30	30	30	0	0	100%	0	0	0
Administration and Operations	14	14	14	14	14	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	18	0	0	100%	0	0	0
TOTAL	**199**	**181**	**199**	**192**	**192**	**7**	**0**	**97%**	**5**	**9**	**2**

[1] A total of 85 elements were reviewed in the previous review period; of these 85, 68 were *Met*, 17 were *Not Met;* 0 was *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.
[2] The MCO was subject to a full review in this review period. All elements were subject to review.
[3] Elements that were *Met* in this review period.
[4] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.
[5] QM20 was added as a new element in 2022.
*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Corrective Action Plans (CAPs) as applicable.
** A typo was noted in the Not Met Total after the finalized CM Reports were sent to the ABHNJ.

ABHNJ Performance Improvement Projects

ABHNJ PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

PIP Topic 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

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

7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**	**M**
Element 7 Overall Score	**N/A**	**N/A**	**50**	**50**	**100**
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**	**10.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	PM	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	**N**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**37.5**	**42.5**	**67.5**	**92.5**
Overall Rating	**N/A**	**62.5%**	**65.4%**	**67.5%**	**92.5%**

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

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Aetna Better Health of New Jersey
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Kristina McShane (kmcshane@ipro.org)
Date (report submission) reviewed: November 22, 2022
Report Period: Final Report
IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant 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). Two (2) minor data corrections were identified. Firstly, on page 33 Barrier Analysis, Table 1a, Barrier 2a, the end date for this Barrier is stated as 3/31/2019, however on Table 1b, ITM 2a continues throughout the life of the PIP; secondly, on page 60 under Final Update Sustainability Year, Indicator 1 (96,15 versus a goal of 97.77%) 96,15 should be represented as a percentage 96.15%.
Element 6 Overall Review Determination was that the MCO is compliant.

Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that a healthcare disparity is not addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 92.5 points, which results in a rating of 92.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant strides in review of the PIP and its elements. The MCO has engaged fully with two (2) of the three (3) providers participating in the PIP as well as continued to outreach Provider 2 with some success. Each provider made gains throughout the life of the PIP; Provider 2 did slide back toward their initial presentation. Each Provider exhibited gains in depression screenings which may account for the increased focus because of the COVID-19 Virus and the effects of social isolation given shutdowns, office closures, as well as limiting outside exposure regarding potential infection. The MCO identified that Providers 1 and 2 got off to a difficult start. However, Provider 1 collaborated with the MCO creating a tool for risk screenings during the transition from a paper medical record to an Electronic Medical Record (EMR). This one transition lifted this provider to be the most consistent and effective provider for the risk screenings. Provider 2 also made strides despite multiple difficult transitions such as reorganization, upgrade to the EMR system and others, however in the end fell back in documenting screenings for the adolescents. Provider 3 started as a strong, consistent participant in the PIP and continued to remain in that steady state over the life of the PIP. One notable lesson the MCO has discussed, was that technology was a valuable tool to enhance results, engage with staff, providers and the MCO continuing to be accessible and providing pertinent information timely. Additionally, the Abstract instruction stated as not to exceed two (2) pages, however the MCO exhibited five (5) pages. The MCO should be mindful in review of a Final Report that all requirements are updated and data is accurate for an effective and comprehensive evaluation.

ABHNJ PIP 2: Improving Access and Availability to Primary Care for the Medicaid Population

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

PIP Topic 2: Improving Access and Availability to Primary Care for the Medicaid Population

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			

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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**M**			
Element 3 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**0.0%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Aetna Better Health of New Jersey
IPRO Reviewers: Donna Reinholdt (dreinholdt@IPRO.org);
Date (report submission) reviewed: November 2, 2022
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 compliant.

Element 4 Overall Review Determination was that the MCO is compliant.

Element 5 Overall Review Determination was that the MCO is partially compliant regarding Robust Interventions, 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). On page 26, Table 1b, Y1 Q1, 0/5=NA, Y1 Q2 exhibits the same result when the calculation should be reflective of 0.00% as noted in Intervention #7 0/996=0,00% although the calculation is correct, there is a comma where there should a period which is inaccurate. The MCO should review numeric calculations for accuracy, updating as appropriate.

Element 6 Overall Review Determination was that the MCO is compliant.

Element 7 Overall Review Determination was that the MCO is compliant.

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

Element 9 Overall Review Determination was that 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 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Concerns identified in the Proposal regarding the PIP Template and modifications made by the MCO have been addressed however the MCO could align start and end dates (Ex: pgs. 18-19) with the ITM for accuracy and clarity. Additionally, the MCO may note that sections of the PIP (Sections 7 & 8) are represented a landscape versus portrait as in the PIP template. The MCO should address the concerns noted and update for the next submission in 2023. The MCO has made adjustments to expand the population and updated the information, with explanations for each change for example updating the Baseline as a change in Methodology to reflect the use of Tax Identification Numbers (TINs) for accuracy and consistency over the life of the PIP. The MCO notes that collaborations with the provider practices has been a positive experience and

understand the importance of the project. The MCO has made many strides and progress to form a well-developed PIP to achieve the stated goals.

ABHNJ PIP 3: Increasing Early and Periodic Screening Diagnostic and Treatment (EPSDT) Visits and Childhood Immunizations

MCO Name: Aetna Better Health of New Jersey

PIP Topic 3: Increasing Early and Periodic Screening Diagnostic and Treatments (EPSDT) Visits and Childhood Immunizations

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**M**			
Element 3 Overall Score	**N/A**	**100**	0	0	0
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			
	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%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Aetna Better Health of New Jersey
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
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 compliant.
Element 4 Overall Review Determination was that the MCO is compliant.

Element 5 Overall Review Determination was that the MCO is partially compliant regarding Robust Interventions, 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). A concern was identified regarding calculation accuracy on page 9, Indicator #1 Short Term Goal, the MCO should remove the comma and replace with a period to exhibit 47.66%, on page 23, 158/628=21.16% which should exhibit 25.16% and on page 26, 68/905=7.35%, which should exhibit 7.51%. The MCO should review all calculations to ensure accuracy of the calculations and providing consistent documentation throughout the life of the PIP.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that Healthcare disparities have been identified and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 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 review Start and End dates which should correspond and align with the ITM or group of ITMs for consistency and reader ease. For example, on Table 1a, ITM #1a, "1a & 1b Start: 1/1/2022 End: 12/31/2024", are aligned with #1a and 1a1 & 1b1 Start: 7/1/2022 End: 12/31/2024 are aligned with 1b & 1b1. Accurate documentation for Start and End dates is important as Table 1a aligns with Table 1b. The MCO should be consistent in aligning the Start and End dates. The MCO has updated the baseline to 2021, made the appropriate adjustments to the data noting a decline in the first quarters of 2022 for all four indicators. The MCO has also identified limiting factors, such as the use of provider addresses which did not yield the member volume expected however, adjusted to data capture to using TINs allowing expansion of the membership population. The MCO should address the concern noted above and continue to review and adjust as the PIP progress.

ABHNJ PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management

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

PIP Topic 4: Decreasing Gaps in Care in Managed Long Term Services and Supports

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M	M	M
1b. Impacts the maximum proportion of members that is feasible		M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M	M	M
1d. Reflects high-volume or high risk-conditions		M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	PM	M	M
Element 1 Overall Review Determination		**PM**	**PM**	**M**	**M**
Element 1 Overall Score	**0**	**50**	**50**	**100**	**100**
Element 1 Weighted Score	**0**	**2.5**	**3**	**5**	**5**

Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M	M	M
2c. Objectives align aim and goals with interventions		M	M	M	M
Element 2 Overall Review Determination		**M**	**M**	**M**	**M**
Element 2 Overall Score	**0**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**0**	**5.0**	**5.0**	**5.0**	**5**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M	M	M
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		PM	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M	M	M
Element 3 Overall Review Determination		**PM**	**M**	**M**	**M**
Element 3 Overall Score	**0**	**50**	**100**	**100**	**100**
Element 3 Weighted Score	**0**	**7.5**	**15**	**15**	**15**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M	M	M

4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings		M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M	M	M
4f. Literature review		M	M	M	M
Element 4 Overall Review Determination		**M**	**M**	**M**	**M**
Element 4 Overall Score	**0**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**0**	**15.0**	**15**	**15**	**15**
Element 5. Robust Interventions [1] (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	N/A	M	M
5b. Actions that target member, provider and MCO		M	N/A	M	M
5c. New or enhanced, starting after baseline year		M	N/A	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)		NM	N/A	PM	PM
Element 5 Overall Review Determination		**PM**	**N/A**	**PM**	**PM**
Element 5 Overall Score	**0**	**50**	**0**	**50**	**50**
Element 5 Weighted Score	**0**	**7.5**	**0**	**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	NM	PM	M	M
Element 6 Overall Review Determination	**N/A**	**NM**	**PM**	**M**	**M**
Element 6 Overall Score	**N/A**	**0**	**50**	**100**	**100**
Element 6 Weighted Score	**N/A**	**0.0**	**2.5**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	PM	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**	**M**
Element 7 Overall Score	**N/A**	**0**	**50**	**50**	**100**
Element 7 Weighted Score	**N/A**	**0.0**	**10**	**10**	**20**

Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**0**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**0**	**20**	**20**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N/A	**N**	N	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	55.0	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	N/A	**37.5**	**50.0**	**82.5**	**92.5**
Overall Rating	N/A	**62.5%**	**76.9%**	**82.5%**	**92.5%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Findings Phase).

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Aetna Better Health of New Jersey
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Report Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination is that the MCO is partially compliant regarding Robust Interventions 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). A concern was identified regarding Table 1b quarterly data, Year 2 Quarters 2 and 3, noting inconsistent decimal documentation and incorrect calculations on page 28, (Intervention/ITM 2a, Y2 Q2; Y2 Q3). The MCO should review for decimal rounding conventions to maintain accuracy of data over the life of the PIP. Additionally, on page 32, Section 6, Results Table 2, Indicator #1 Original Methodology, should be grayed out and Indicator #2, Original Methodology, should be grayed out as noted there was a change in Methodology. This change should also be reflected in the Methodology Section for clarity in change of process and the date of the Change should be documented on the Change Table. The MCO should review the concerns and make adjustments and/or modifications.
Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination is that the MCO is compliant.
Element 8 Overall Review Determination is that the MCO is compliant.
Element 9 Overall Review Determination is that the MCO did not address a healthcare disparity.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 92.5 points, which results in a rating 92.5% (which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has made a comprehensive review and significant adjustments to improve the stability and quality of the PIP. The MCO identified multiple barriers to achieving the goals of the PIP, however by team collaboration, brainstorming, re-validation of data, termination of some interventions and initiating others gave the MCO the ability to continue forward movement toward the goals. The MCO utilized resources, committee feedback and trial and error approaches gaining more insight to what the MCO was able to provide member support within the given resources available. To that end, although the MCO was not able to achieve the Long-Term Goals, the MCO did see positive results in decreasing the use of ER and IP admissions through the implementation of intensive care coordination and a focus on improving self-management skills for members with a diagnosis of CHF and/or COPD.

ABHNJ PIP 5: Improving Coordination of Care and Ambulatory Follow up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: Aetna Better Health of New Jersey
PIP Topic 5: Improving Coordination of Care and Ambulatory Follow up After Mental Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	N/A	**M**			
Element 3 Overall Score	N/A	**100**	0	0	0
Element 3 Weighted Score	N/A	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			
	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**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Aetna Better Health of New Jersey
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org);
Date (report submission) reviewed: October 18, 2022
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 compliant.

Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was Healthcare disparities are being identified and reviewed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has updated the PIP template ensuring an accurate and comprehensive review over the life of the PIP. Of note, a minor concern regarding Start and End dates in the Barrier analysis should be in alignment with the ITMs. The MCO should review and update for reader ease and decrease potential confusion. The MCO notes that PI #1 essentially has remained flat although PI #2 has made slight increase from the baseline rate. The MCO also has identified SDOH issues during the inpatient stays, increased communications between BH UM and MLTSS CM ensuring information is shared for admissions and aftercare. One limitation noted is the volume of eligible members for inclusion in the PIP continues to low although there has been growth in the FIDE SNP membership which may provide an increase in volume over time. The MCO should continue to monitor progress, adjusting as needed documenting all the changes in the respective sections over the life of the PIP.

ABHNJ – HEDIS Audit Review Table MY 2021

Audit Review Table					
Aetna Better Health of New Jersey (Org ID: 236303, Sub ID: 15442, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2021; Date & Timestamp - 6/13/2022 12:08:04 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		84.67%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		81.27%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		78.35%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		70.56%	R	R	Reported
Childhood Immunization Status - IPV		84.43%	R	R	Reported
Childhood Immunization Status - MMR		84.91%	R	R	Reported
Childhood Immunization Status - HiB		86.13%	R	R	Reported
Childhood Immunization Status - Hepatitis B		79.56%	R	R	Reported
Childhood Immunization Status - VZV		84.67%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		64.96%	R	R	Reported
Childhood Immunization Status - Hepatitis A		76.4%	R	R	Reported
Childhood Immunization Status - Rotavirus		64.23%	R	R	Reported
Childhood Immunization Status - Influenza		52.07%	R	R	Reported
Childhood Immunization Status - Combo 3		57.91%	R	R	Reported
Childhood Immunization Status - Combo 7		45.74%	R	R	Reported
Childhood Immunization Status - Combo 10		34.79%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		83.45%	R	R	Reported
Immunizations for Adolescents - Tdap		86.86%	R	R	Reported
Immunizations for Adolescents - HPV		30.66%	R	R	Reported
Immunizations for Adolescents - Combination 1		82.24%	R	R	Reported
Immunizations for Adolescents - Combination 2		28.71%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		66.67%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		43.33%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		48.18%	R	R	Reported
Chlamydia Screening in Women (CHL)					

Chlamydia Screening in Women (Total)		63.43%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		69.77%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		35.71%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		82.93%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		88.62%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		68.21%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		57.66%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		64.29%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		79.93%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		72.02%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		1.04%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		3.65%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		4.17%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		3.13%	R	R	Reported
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing		87.1%	R	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		35.77%	R	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		54.26%	R	R	Reported
Comprehensive Diabetes Care - Eye Exams		50.12%	R	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		58.39%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		33.38%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		66.77%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		66.48%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Antidepressant Medication Management - Effective Acute Phase Treatment		62.45%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		45.69%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		36.88%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		36.11%	R	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		40.23%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		23.57%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		58.01%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		52.32%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		40.93%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		20.29%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		17.76%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		12.4%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		20.47%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		86.38%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		64.37%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		62.5%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		52.92%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				

Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		57.24%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		40%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		40%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.45%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		87.29%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		57.32%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain		74.33%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		9.68%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		18.76%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		3.11%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		1.84%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		5.21%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		3.02%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		68.27%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (Total)		46.35%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		40.19%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		6.6%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		63.29%	R	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		27.41%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		40.44%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		4.23%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		44.69%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		11.43%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		86.13%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		78.59%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		60.42%	R	R	Reported
Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		52.4%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		70.35%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		55.89%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMBa)			R	R	Reported
Ambulatory Care (Dual) (AMBb)			NQ	NQ	Not Required
Ambulatory Care (Disabled) (AMBc)			NQ	NQ	Not Required
Ambulatory Care (Low Income) (AMBd)			NQ	NQ	Not Required
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Dual) (IPUb)			NQ	NQ	Not Required
Inpatient Utilization - General Hospital/Acute Care (Disabled) (IPUc)			NQ	NQ	Not Required
Inpatient Utilization - General Hospital/Acute Care (Low Income) (IPUd)			NQ	NQ	Not Required
Identification of Alcohol and other Drug Services (IADa)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Dual) (IADb)			NQ	NQ	Not Required
Identification of Alcohol and Other Drug Services (Disabled) (IADc)			NQ	NQ	Not Required

Identification of Alcohol and Other Drug Services (Low Income) (IADd)			NQ	NQ	Not Required
Mental Health Utilization (MPTa)	Y		R	R	Reported
Mental Health Utilization (Dual) (MPTb)			NQ	NQ	Not Required
Mental Health Utilization (Disabled) (MPTc)			NQ	NQ	Not Required
Mental Health Utilization (Low Income) (MPTd)			NQ	NQ	Not Required
Antibiotic Utilization (ABXa)	Y		R	R	Reported
Antibiotic Utilization (Dual) (ABXb)			NQ	NQ	Not Required
Antibiotic Utilization (Disabled) (ABXc)			NQ	NQ	Not Required
Antibiotic Utilization (Low Income) (ABXd)			NQ	NQ	Not Required
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENPa)			R	R	Reported
Enrollment by Product Line (Dual) (ENPb)			NQ	NQ	Not Required
Enrollment by Product Line (Disabled) (ENPc)			NQ	NQ	Not Required
Enrollment by Product Line (Low Income) (ENPd)			NQ	NQ	Not Required
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Electronic Clinical Data Systems					
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		43.16%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		36.88%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		36.11%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0%	R	R	Reported

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza		8.72%	R	R	Reported
Adult Immunization Status - Td/Tdap		15.98%	R	R	Reported
Adult Immunization Status - Zoster		2.31%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		17.82%	R	R	Reported
Prenatal Immunization Status - Tdap		37.06%	R	R	Reported
Prenatal Immunization Status - Combination		13.09%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2022 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	24	30	23	23	7	0	77%	5	1	2
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	9	14	10	10	4	0	71%	4	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	21	18	21	19	19	2	0	90%	2	0	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	7	7	2	0	78%	0	0	2
Programs for the Elderly and Disabled	44	44	44	44	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	11	11	11	0	0	100%	0	0	0
Satisfaction	5	5	5	5	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	7	7	1	0	87%	0	0	1
Credentialing and Recredentialing	10	10	10	10	10	0	0	100%	0	0	0
Utilization Management	30	30	30	30	30	0	0	100%	0	0	0
Administration and Operations	14	14	14	14	14	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	18	0	0	100%	0	0	0
TOTAL	**199**	**191**	**199**	**190**	**190**	**9**	**0**	**95%**	**6**	**1**	**3**

[1] A total of 85 elements were reviewed in the previous review period; of these 85, 78 were *Met,* 7 were *Not Met;* 0 were *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] The MCO was subject to a full review in this review period. All elements were subject to review.

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

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

[6] QM20 was added as a new element in 2022.

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

AGNJ Performance Improvement Projects

AGNJ PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: Amerigroup New Jersey
PIP Topic 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM	PM	M	M
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**M**
Element 3 Overall Score	**N/A**	**50**	**50**	**100**	**100**
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 4 Overall Score	**N/A**	**50**	**100**	**100**	**100**
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M	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	NM	N/A	PM	PM
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**	**PM**	**PM**
Element 5 Overall Score	**N/A**	**50**	**N/A**	**50**	**50**
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	PM	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**PM**	**M**	**M**
Element 6 Overall Score	**N/A**	**100**	**50**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**2.5**	**5.0**	**5.0**

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**37.5**	**45.0**	**82.5**	**72.5**
Overall Rating	**N/A**	**62.5%**	**69.2%**	**82.5%**	**72.5%**

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

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Kristina McShane (kmcshane@ipro.org)
Date (report submission) reviewed: November 22, 2022
Review: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant regarding the subcomponent 5c, New or enhanced, starting after baseline year. Concerns were identified with Interventions/Intervention Tracking Measures (ITMs) in terms of provider count. The MCO was advised in previous submissions that it is insufficient to report only in terms of the provider count (which are only three (3) providers). Recommendations to the MCO regarding the expansion of Interventions might have included data informing on adolescent well visits without screening in comparison to well visits with screenings as well as educational opportunities for the members regarding the importance of the health risk behavior screenings. Improvement and/or expansion of Interventions/ITMs is integral for sufficiently evaluating the progress of the interventions over the life of the PIP. Additionally, 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). On page 41, Table 1b exhibits MY 1 and MY 2, however the MCO did not include the Sustainability Year data in Table 1b for the Final Report. MCO should have provided all the relevant quarterly data in support of the sustainability results to the specified tables along with corresponding comments.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant with subcomponent 7c, Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity. On page 61, the MCO did not identify any internal factors that pose a threat, although an external threat, Covid-19 may have contributed to the decline in adolescent well visits. Office closings, alternate schedules, and member well visits declined due the fear of potential exposure to the virus. The external potential validity threats could be explained in more detail. For example, for sexual behaviors, only one of the three providers met the sexual behavior goal which may be due to Covid-19 fear. Additionally, office closings and alternate scheduling, as well as the use of Telehealth may have impacted MCO goals. Telehealth was both useful for member outreach and virtual assessments, however, may have been a deterrent in discussing sexual risk behaviors with parents in the room. This one issue could call into question the validity of this screening intervention. The MCO might review and discuss any other factors that could pose a threat to the validity of the data and outcomes. Secondly, 7d, Lessons Learned & follow-up activities planned as a result, the MCO notes that provider engagement proves to be a key contributing factor in meeting the objective of the study and plans to continue this approach for risk behaviors moving forward. The MCO also notes that during the Pandemic the MCO needed to modify communications to providers to provide education, results of screenings, and gaps in care. Due to technical difficulties at the provider offices, the MCO's communications were telephonic, email, or faxes. However, the MCO does not discuss how well this information was received or the feedback from the providers. The MCO should detail how this approach was successful in providing the information needed to move the project forward and assist the providers with understanding any potential or real gaps in care so they could be addressed during the Pandemic as well as ongoing.
Element 8 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 8a, there were ongoing, additional, or modified interventions documented. As noted above under Element 5d, the MCO did not implement new or modified interventions/ITMs, which may have been useful in evaluating the status of adolescent well visits compared to Baseline over each measurement year as well as what interventions

are sustainable over time. The addition of a member /provider survey or other enhancement could have helped to better understand the actual impact of the COVID-19 virus: staffing challenges, adjustments to office practices, scheduling, and nuances such as the implementation of Telehealth for a comprehensive assessment of the PIP. Additionally, 8b, Sustained improvement was demonstrated through repeated measurements over comparable time periods, the MCO did not provide quarterly monitoring data for the Sustainability Year. Although the MCO did report the year end data for the Performance Indicators, it is not evident that the interventions supporting the outcomes cited is sustainable. The MCO should provide the quarterly data which supports the sustainability of the outcomes presented.
Element 9 Overall Review Determination is that the MCO was unable to identify any disparities.
Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points the MCO scored 72.5 points, which results in a rating of 72.5%. (This is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made substantial strides during challenging times and has made good observations that can better serve the membership for adolescent population. The MCO has identified the Provider Portal as the main place where ongoing education and updates can be readily accessible for the providers to share with members, thereby expanding the use of risk behavior tools and knowledge to the broader membership. The MCO has incorporated adolescent risk screening into its annual medical record review which can be communicated to the Provider Advisory Committee and Quality Management Committee as appropriate.

AGNJ PIP 2: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

MCO Name: Amerigroup New Jersey (AGNJ)
PIP Topic 2: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M		
Element 1 Overall Review Determination	N/A	**M**	**M**		
Element 1 Overall Score	N/A	**100**	**100**	**0**	**0**
Element 1 Weighted Score	N/A	**5.0**	**5.0**	**0.0**	**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	PM	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M		

2c. Objectives align aim and goals with interventions	N/A	PM	M		
Element 2 Overall Review Determination	N/A	**PM**	**M**		
Element 2 Overall Score	N/A	**50**	**100**	**0**	**0**
Element 2 Weighted Score	N/A	**2.5**	**5.0**	**0.0**	**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	PM	M		
3b. Performance indicators are measured consistently over time	N/A	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	N/A	**PM**	**M**		
Element 3 Overall Score	N/A	**50**	**100**	**0**	**0**
Element 3 Weighted Score	N/A	**7.5**	**15.0**	**0.0**	**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	PM	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M		
4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	N/A	**PM**	**M**		
Element 4 Overall Score	N/A	**50**	**100**	**0**	**0**
Element 4 Weighted Score	N/A	**7.5**	**15.0**	**0.0**	**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	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M		
Element 5 Overall Review Determination	N/A	**M**	**M**		
Element 5 Overall Score	N/A	**100**	**100**	**0**	**0**
Element 5 Weighted Score	N/A	**15.0**	**15.0**	**0.0**	**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	M	M		
Element 6 Overall Review Determination	N/A	**M**	**M**		
Element 6 Overall Score	N/A	**100**	**100**	**0**	**0**
Element 6 Weighted Score	N/A	**5.0**	**5.0**	**0.0**	**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	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	N/A	**M**	**PM**		
Element 7 Overall Score	N/A	**100**	**50**	**0**	**0**
Element 7 Weighted Score	N/A	**20.0**	**10.0**	**0.0**	**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	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**	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**

Actual Weighted Total Score	**N/A**	**62.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**78.1%**	**87.5%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org);
Date (report submission) reviewed: November 2, 2022
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is complaint.
Element 7 Overall Review Determination was that the MCO was partially compliant regarding 7b, Data presented adheres to the statistical techniques outlined in the MCO's data analysis plan. On page 18, Quarterly Reporting, Table 1b, Yr. 1, Q3, Intervention/ITM 2c was identified to have a calculation error exhibiting 894/2342=36.02% when the calculation should reflect 894/2342=38.17%. Additionally, on page 18, ITM 3a exhibits the calculation of 0/0=0% when the rate should be reflected as NA, noting when there is a zero in the denominator, the rate should be NA. Also on page 19, Intervention/ITM3c and 4a are identified as new interventions initially to Start in Q2 of 2022 however, there has been a delay in the Start time noted in the footnote but has not been updated in the Barrier Analysis or the Change Table. The MCO should review the concerns and numeric calculations prior to submission to ensure accurate and consistent data throughout the life of the PIP for a comprehensive evaluation of the project.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that 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 67.5 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that expresses the intended impact on performance outcomes, including consider keeping the percentage rate format consistent throughout all tables (Example: Table 2 varies in percentage format from Table 1b). The MCO appropriately continues to understand the initial delay in implementation of the project may have an ultimate impact on the outcome of the project, however, continues move forward adding additional Interventions and adjusting according to the data. The MCO has made adjustments to the recommendations providing increased clarity and understanding the progress of each measurement year. The MCO should continue to adjust continuing to provide consistency and clarity with descriptions and specifications across the interventions, corresponding ITMs and result outcomes over the life of the PIP.

AGNJ PIP 3: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

MCO Name: Amerigroup New Jersey

PIP Topic 3: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	PM			
2c. Objectives align aim and goals with interventions	**N/A**	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM			
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	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 (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (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	**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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**67.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**84.4%**	**0.0%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
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 partially compliant regarding 2b, goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. On page 8, bullet 2, Aim Statement, Objectives, and Goals, the MCO's Baseline continues to reflect 2019 Baseline data as noted on page 12, Measurement Periods. During the 2022 Annual NJ MCO PIP Training, the baseline for EPSDT PIP instruction was "Please note for the EPSDT PIP, Baseline

information for all MCO's should reflect MY 2021. HEDIS data will be available in June of 2022 and should be updated in the August 2022 Report Submission."
Element 3 Overall Review Determination was that the MCO is partially compliant regarding 3a, Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria). As noted above, on page 8, the MCO has identified by footnotes Performance Indicators #1 and #2 there have been updates to Well Child measure. The MCO should have used MY 2021 for the Baseline Rate inclusive of numerator and denominator. The MCO should update the information for the Baseline and corresponding Tables/ Sections that may impacted by the baseline update to 2021.
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 partially complaint regarding 6a, Table 2 exhibits Performance Indicator Rates, numerators, and denominators, with corresponding goals. A concern was identified with the Results Table 2, the Baseline data was cited in a footnote as "W15 measure was revised to Well-Child Visit in First 30 Months of Life (W30) for MY2020-current". The Baseline Period cites 2019 as the MY for the Baseline. However, as noted above the Baseline should exhibit MY 2021 for the PIP to be represented in alignment with all MCO's regarding the EPSDT PIP. The MCO should update the Baseline to 2021 for the Indicator Rates and align data based on the Baseline for 2021.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the year 1 phase.
Element 9 Overall Review Determination was that the MCO has not identified any Healthcare disparities.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 67.5 points, which results in a rating of 84.4%. (Which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that is demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are documented in the respective Sections of the April and August 2023 Report submissions.

AGNJ PIP 4: Decreasing Gaps in Care in Managed Long Term Services and Supports

MCO Name: Amerigroup New Jersey (AGNJ)
PIP Topic 4: Decreasing Gaps in Care in Managed Long Term Services and Supports

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
	Proposal Findings	Year 1 Findings	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	PM	M	M
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M	M	M
1d. Reflects high-volume or high risk-conditions	N/A	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	PM	M	M	M
Element 1 Overall Review Determination	N/A	**PM**	**PM**	**M**	**M**
Element 1 Overall Score	N/A	**50**	**50**	**100**	**100**
Element 1 Weighted Score	N/A	**2.5**	**2.5**	**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	N/A	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M	M	M
2c. Objectives align aim and goals with interventions	N/A	M	M	M	M
Element 2 Overall Review Determination	N/A	**M**	**M**	**M**	**M**
Element 2 Overall Score	N/A	100	**100**	**100**	**100**
Element 2 Weighted Score	N/A	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	PM	M	M	M
3b. Performance indicators are measured consistently over time	N/A	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	N/A	**PM**	**M**	**M**	**M**
Element 3 Overall Score	N/A	**50**	**100**	**100**	**100**
Element 3 Weighted Score	N/A	**7.5**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	NM	PM	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M

Element 4 Overall Review Determination	N/A	**M**	**PM**	**PM**	**M**
Element 4 Overall Score	N/A	**100**	**50**	**50**	**100**
Element 4 Weighted Score	N/A	**15.0**	**7.5**	**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	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	PM	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM	PM
Element 5 Overall Review Determination	N/A	**PM**	**N/A**	**PM**	**PM**
Element 5 Overall Score	N/A	**50**	**N/A**	**50**	**50**
Element 5 Weighted Score	N/A	**7.5**	**N/A**	**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	NM	PM	M	M
Element 6 Overall Review Determination	**N/A**	**NM**	**PM**	**M**	**M**
Element 6 Overall Score	**N/A**	**0**	**50**	**100**	**100**
Element 6 Weighted Score	**N/A**	**0**	**2.5**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	PM	PM	PM
Element 7 Overall Review Determination	N/A	N/A	PM	**PM**	**PM**
Element 7 Overall Score	**N/A**	**N/A**	**50**	**50**	**50**
Element 7 Weighted Score	**N/A**	**N/A**	**10**	**10.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM	PM
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	**PM**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**50**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**10.0**

Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed **(Y=Yes N=No)**	N/A	**N**	**N**	**N**	**Y**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	N/A	**60.0**	**65**	**100**	**100**
Actual Weighted Total Score	N/A	**37.5**	**42.5**	**65.0**	**72.5**
Overall Rating	N/A	**62.5%**	**65.4%**	**65.0%**	**72.5%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination is that the MCO was partially compliant regarding Robust Interventions, 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). Table 1b, pages 29-37 continue to exhibit multiple NAs, asterisk and numeric writing conventions that are inconsistent throughout the table. There is insufficient data for MY 1, MY 2, the Sustainability data was not populated in Table 1b, nor is it in a format where the reader could review the data quarter by quarter to understand the data progression regarding the potential sustainability. On page 39, Table 2 Results, does exhibit SY 2021 data for the Performance indicators. The MCO has cited data challenges in previous submissions however there does not appear to have a defined solution or explanation of progress toward a resolution regarding these data challenges. The MCO should review its ability to effectively data mine and display information to support future projects.
Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant regarding 7d. Lessons learned & follow-up activities planned as a result. A concern was identified regarding overall understanding of the progress made and its sustainability in terms of process improvement. It is difficult to fully understand the follow-up activities with low volume data especially regarding Sustainability quarterly monitoring. The Sustainability Year allows the reader as well as the MCO to finalize what interventions made progress and what interventions are sustainable and/or reasonable for the MCO to expand to the larger membership over time.
Element 8 Overall Review Determination was that the MCO is partially compliant regarding Sustainability 8b, sustained improvement was demonstrated through repeated measurements over comparable time periods. As noted in the previous submission as well as above, there was insufficient data to effectively evaluate progress of the PIP year over year. Table 1b remains with incorrect notations and writing conventions for the data and footnotes. In the Final Report, the MCO should have reviewed each section for any additional data, comment on challenges and the outcomes noted in detail.
Element 9 Overall Review Determination is that the MCO did recognize SDoH concern regarding Home Delivered Meals as healthcare disparity and is addressing this concern.
Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 72.5 points, which results in a rating of 72.5% (which is below 86% [≥ 86% being the

threshold for meeting compliance]). The MCO acknowledges Performance Indicator (PI) 1 regarding MLTSS members living in the community that received a Flu Vaccine did not meet the Long-Term Goal, declining year over year. The MCO identified multiple issues that may have impacted this performance indicator, noting Covid-19 virus appears to have the most significant impact. PI #2, did not meet the Long-Term Goal, although came close. The MCO did identify SDOH (food insecurity) during the last year of the PIP and will continue to focus on this performance indicator, implementing steps to assist members needing these services. The MCO should address the above concerns with clarifications, adjustments and more detailed explanations of intervention/ITMs progress or decline for a well-developed PIP that demonstrates the intended impact on performance outcomes.

AGNJ PIP 5: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population

MCO Name: Amerigroup New Jersey
PIP Topic 5: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS HCBS Population

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	N/A	**M**			
Element 3 Overall Score	N/A	**100**	0	0	0
Element 3 Weighted Score	N/A	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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 (Y=Yes, N=No)	**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**	**Y**			

	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%**	**0.0%**	**0.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 18, 2022
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is complaint.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant 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). On page 16, Intervention 2a start date is noted as 4/1/2022. The numerator/denominator and rate are noted as 0/0=0% although this intervention was not implemented during the first quarter of 2022. The MCO should update the documentation to reflect NA/NA with a rate of NA as there is no data to cite as well as footnote the reason for the NA label at the bottom of Table 1b. There are multiple labels of NA that should also have a footnote explaining the reason behind the NA. The MCO should updated Table 1b and add the respective footnotes.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that the MCO is implementing processes to evaluate Healthcare disparities.
Overall, the MCO was 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 90.6% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO acknowledges there have been no notable successes or failures however, in the initial months the MCO continues to review each intervention, adjusting as data and implementing additional interventions along the way. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that is demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are documented in the April and August 2023 submissions.

MCO Name: Amerigroup New Jersey (AGNJ)

PIP Topic 6: Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population

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

3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	PM
Element 3 Overall Review Determination	N/A	**M**	**M**	**M**	**PM**
Element 3 Overall Score	N/A	**100**	**100**	**100**	**50**
Element 3 Weighted Score	N/A	**15.0**	**15.0**	**15.0**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	PM	PM	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	N/A	**M**	**PM**	**PM**	**M**
Element 4 Overall Score	N/A	**100**	**50**	**50**	**100**
Element 4 Weighted Score	N/A	**15.0**	**7.5**	**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	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	PM	N/A	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM	PM
Element 5 Overall Review Determination	N/A	**PM**	**N/A**	**PM**	**PM**
Element 5 Overall Score	N/A	**50.0**	**N/A**	**50**	**50**
Element 5 Weighted Score	N/A	**7.5**	**N/A**	**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	PM	M	M
Element 6 Overall Review Determination	**N/A**	**PM**	**PM**	**M**	**M**
Element 6 Overall Score	**N/A**	**50.0**	**50**	**100**	**100**
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion					

of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	PM	PM	PM
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	PM
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**	**PM**
Element 7 Overall Score	**N/A**	**N/A**	**50.0**	**50**	**50**
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**	**10.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	PM
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**PM**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**50**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**10.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)		**N**	**N**	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**47.5**	**45.0**	**75.0**	**65.0**
Overall Rating	**N/A**	**79.2%**	**69.2%**	**75.0%**	**65.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Amerigroup New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is partially compliant regarding 3h, Study design specifies data analysis procedures with a corresponding timeline. The MCO identified data challenges throughout the life of the PIP. Although the Covid-19 Pandemic was a significant intervening factor for MY 2020 and 2021, the MCO has made modifications such as telephonic educations versus face-to-face during the height of the Pandemic. However, over each measurement year, the MCO should have reviewed and captured

any data that may not have been available at the time of reporting and updated the respective tables which may have increased some of the data as noted in footnotes *** Rate reported collectively in subsequent quarter- See Section 7- Discussion of Results in applicable update year; **** Rate not available due to challenges with data capture- See Section 7- Discussion of Results in applicable update year on page 25. In the Final Report, a complete review of the study design, data capture and all respective sections should be reviewed, updated to reflect the up-to-date information for an accurate and comprehensive evaluation of progress and/or limitations and challenges over the life of the PIP.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant 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). On pages 23-25, Table 1b, MY 1 lacks enough data to evaluate effectively progress and MY 2 exhibits low volumes in almost all interventions/ITMs with the exceptions of Interventions/ITMs #3 and #6. The MCO does footnote below Table 1b, however, might have considered updating Table 1b when data was available and discussing the update in Section 7 as well as adjusting the footnotes accordingly. Additionally, Sustainability Year (SY) only includes Q1 2021 and Q2 2021 data. On page 27, Table 2 exhibits SY 2021 data for the Performance Indicators #1 and #2 exhibits the Final Results, however, the MCO does not display quarterly reporting for sustainability in table format validating the resulting data. The MCO has cited data challenges in previous submissions however continues to lack defined solutions or explanations of progress to the resolution of data concerns. For the Final Report, the MCO should review all sections for completeness, its ability to effectively data display data and ensure data accuracy for the reader to understand progress, challenges, and ultimate outcomes to support future projects.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant regarding subcomponent 7a, Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions). The MCO acknowledges that the final Goals were not met for Performance Indicators (PIs) #1 and #2, however both exhibited downward trends. The MCO does not fully explain what interventions contributed to the success in the downward trending of the PIs and should detail the contributing factors. The MCO does identify adjustments and modifications made over the life of the PIP due to the Covid-19 Pandemic, noting the pandemic was a significant factor in meeting new challenges regarding not being to implement face-to-face Fall Prevention Education for Nursing Facility and Assisted Living Staff and members. Additionally, 7b, Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan. As noted above, the potential expansion to the MCO membership is obtained from the ability to sustain the gains related to the PIP objectives and goals. The display of Sustainability data, including all four (4) quarters in table format, would have been helpful in evaluating the sustainability of the Interventions/ITM for reader clarity in understanding the flow of data throughout the life of the PIP. The Sustainability year allows the reader as well as the MCO to finalize what interventions made progress, are sustainable and reasonable for the MCO to expand to the larger membership over time.
Element 8 Overall Review Determination was that the MCO is partially compliant regarding 8b, Sustained improvement was demonstrated through repeated measurements over comparable time periods. Table 1b, on pages 23-25 exhibits multiple concerns regarding data identified as NA, zero or low volume with the expectations for Interventions/ITMs #3 and #6. Regarding Sustainability Year results, only Q1 and Q2 are noted in the Update for 2021 pages 35-38 and on page 39 for 2022 Update exhibits final results for PIs #1 and #2. The Sustainability Year data is incomplete making it difficult to fully understand and rely on the data as presented. The MCO should include all data, updating tables as data is adjusted, modified and/or re-evaluated ensuring the data is complete for each MY inclusive of all quarters of the Sustainability Year as noted above.
Element 9 Overall Review was that a healthcare disparity was not addressed.

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 65.0 points, which results in a rating of 65.0% (which is below 86% [≥ 86% being the threshold for meeting compliance]). The MCO acknowledges progress in the two Performance Indicators as well as use the experience and lessons learned in future projects that will benefit the MCO's membership. The

MCO is considering expanding the Fall Prevention Material to be available to other facilities in the network as well as a potential provider program. Additionally, of note there were miscalculations when updating data that remained in the Final Report. For example, page 10, a correction was made to HCBS value, however the total number of unique members remained unchanged. This one miscalculation also impacted the FRA Unique member percentage value and could be carried through the PIP. The MCO should review each section for all metrics, ensuring that all data is represented in a clear and concise manner, identifying rational for changes and updates at the tables and in the discussion sections to ensure the accuracy of the information carries through measurement year over measurement year.

AGNJ – HEDIS Audit Review Table MY 2021

Audit Review Table					
Amerigroup New Jersey, Inc. (Org ID: 1791, Sub ID: 4308, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2021; Date & Timestamp - 6/14/2022 9:39:00 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		85.16%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		81.51%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.32%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		67.4%	R	R	Reported
Childhood Immunization Status - IPV		83.7%	R	R	Reported
Childhood Immunization Status - MMR		83.21%	R	R	Reported
Childhood Immunization Status - HiB		83.45%	R	R	Reported
Childhood Immunization Status - Hepatitis B		79.56%	R	R	Reported
Childhood Immunization Status - VZV		82.48%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		65.69%	R	R	Reported
Childhood Immunization Status - Hepatitis A		73.24%	R	R	Reported
Childhood Immunization Status - Rotavirus		56.93%	R	R	Reported
Childhood Immunization Status - Influenza		48.42%	R	R	Reported
Childhood Immunization Status - Combo 3		54.5%	R	R	Reported
Childhood Immunization Status - Combo 7		38.44%	R	R	Reported
Childhood Immunization Status - Combo 10		28.95%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		83.74%	R	R	Reported
Immunizations for Adolescents - Tdap		86.7%	R	R	Reported
Immunizations for Adolescents - HPV		28.62%	R	R	Reported
Immunizations for Adolescents - Combination 1		81.79%	R	R	Reported

Immunizations for Adolescents - Combination 2		26.75%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		73.97%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		52.35%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		61.48%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		61.51%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		76.4%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		33.97%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		67.28%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		88.97%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		61.48%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		50.12%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		72.5%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		78.05%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		71.47%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		0.61%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		3.06%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		2.45%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0%	R	R	Reported
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing		85.16%	R	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		36.25%	R	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		54.99%	R	R	Reported
Comprehensive Diabetes Care - Eye Exams		49.39%	R	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		52.31%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					

Kidney Health Evaluation for Patients With Diabetes (Total)		32.35%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		67.88%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		65.32%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		60.78%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		42.96%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		30.63%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		31.11%	R	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		54.17%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		34.72%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		60.13%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		51.97%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		44.16%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		22.26%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		18.38%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		12.93%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		18.74%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		85.46%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		69.88%	R	R	Reported

Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		79.41%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		62.17%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		53.45%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		38.66%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		37.31%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.23%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		89.23%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		52.29%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain		78.67%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.87%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		17.32%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.26%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.78%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		3.09%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		2.12%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		76.34%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (Total)		52.93%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y				

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		35.9%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		2.56%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		57.14%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		0%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		50%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		3.85%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		44.71%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		1.18%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		86.81%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		81.25%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		56.1%	R	R	Reported
Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		48.99%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		75.14%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		62.74%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMBa)			R	R	Reported
Ambulatory Care (Dual) (AMBb)			R	R	Reported
Ambulatory Care (Disabled) (AMBc)			R	R	Reported
Ambulatory Care (Low Income) (AMBd)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Dual) (IPUb)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Disabled) (IPUc)			R	R	Reported

Inpatient Utilization - General Hospital/Acute Care (Low Income) (IPUd)			R	R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Dual) (IADb)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Disabled) (IADc)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Low Income) (IADd)	Y		R	R	Reported
Mental Health Utilization (MPTa)	Y		R	R	Reported
Mental Health Utilization (Dual) (MPTb)	Y		R	R	Reported
Mental Health Utilization (Disabled) (MPTc)	Y		R	R	Reported
Mental Health Utilization (Low Income) (MPTd)	Y		R	R	Reported
Antibiotic Utilization (ABXa)	Y		R	R	Reported
Antibiotic Utilization (Dual) (ABXb)	Y		R	R	Reported
Antibiotic Utilization (Disabled) (ABXc)	Y		R	R	Reported
Antibiotic Utilization (Low Income) (ABXd)	Y		R	R	Reported
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENPa)			R	R	Reported
Enrollment by Product Line (Dual) (ENPb)			R	R	Reported
Enrollment by Product Line (Disabled) (ENPc)			R	R	Reported
Enrollment by Product Line (Low Income) (ENPd)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Electronic Clinical Data Systems					
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening			NR	NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)					
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase			NR	NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase			NR	NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)			NR	NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)			NR	NR	Not Reported

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NR	NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)			NR	NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NR	NR	Not Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza			NR	NR	Not Reported
Adult Immunization Status - Td/Tdap			NR	NR	Not Reported
Adult Immunization Status - Zoster			NR	NR	Not Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		12.78%	R	R	Reported
Prenatal Immunization Status - Tdap		28.35%	R	R	Reported
Prenatal Immunization Status - Combination		8.2%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening			NR	NR	Not Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	NR	Not Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening			NR	NR	Not Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	NR	Not Reported

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2022 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	25	30	25	25	5	0	83%	4	1	1
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	11	14	12	12	2	0	86%	2	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[5]	21	17	21	20	20	1	0	95%	0	3	1
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	44	44	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	11	11	11	0	0	100%	0	0	0
Satisfaction	5	4	5	5	5	0	0	100%	0	1	0
Enrollee Rights and Responsibilities	8	8	8	8	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	10	9	9	1	0	90%	0	0	1
Utilization Management	30	29	30	30	30	0	0	100%	0	0	0
Administration and Operations	14	14	14	14	14	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	18	0	0	100%	0	0	0
TOTAL	**199**	**190**	**199**	**195**	**195**	**4**	**0**	**98%**	**2**	**5**	**2**

[1] A total of 85 elements were reviewed in the previous review period; of these 85, 77 were *Met*, 7 were *Not Met;* 1 was *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] The MCO was subject to a full review in this review period. All elements were subject to review.

[3] Elements that were *Met* in this review period.

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

[5] QM20 was added as a new element in 2022.

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

HNJH Performance Improvement Projects

HNJH PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: Horizon New Jersey Health (HNJH)

PIP Topic 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	N/A	M	M
Element 5 Overall Review Determination	**N/A**	**M**	**N/A**	**M**	**M**
Element 5 Overall Score	**N/A**	**100**	**N/A**	**100**	**100**
Element 5 Weighted Score	**N/A**	**15.0**	**N/A**	**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	N/A	M	M	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**

Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes) (**N**=No)	N	**N**	**Y**	**y**	**Y**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**65.0**	**100.0**	**100.0**
Overall Rating	**N/A**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Kristina McShane (kmcshane@ipro.org)
Date (report submission) reviewed: November 22, 2022;
Report Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.

Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that the MCO addressed healthcare disparities.

Overall, the MCO is compliant with this PIP for the Final Reporting requirement: out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO began the PIP with two (2) high performing providers and one (1) provider that exhibited the most opportunity based on the baseline results. The MCO continue to make strides year over year throughout the life of the PIP, taking steady steps to monitor, document and address any changes as they occurred. All three providers participating in the PIP made great progress during MY 1 and MY 2. In January 2021 (Sustainability Year), one (1) provider withdrew from participation in the PIP. Both practice groups remaining showed improvement or remained constant in screening rates from MY 2 2020 to SY 2021. In instances where screening rates decreased, the decrease was slight. Both practices showed statistically significant improvement in all screenings, except tobacco screening which started out with very high-performance rates from baseline to SY 2021. Both practice groups showed statistically significant improvements in clinical responses to positive screenings from baseline to SY 2021. Clinical response rates were 100% in all categories, except depression, which came in at 87.5% in SY 2021. The MCO understands this is a principle that can absolutely be introduced to other practices for various risk behaviors, depression screenings or other factors that may exhibit the need for increased screening and potential educational opportunities. The MCO has successfully completed the PIP.

HNJH PIP 2: Increasing PCP Access and Availability for Members with Low Acuity, Non-Emergent ED visits

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 2: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**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	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M		

4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**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	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M		
Element 5 Overall Review Determination	**N/A**	**PM**	**M**		
Element 5 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**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	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**0.0**	**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	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**	**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**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**87.5%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
Reporting Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant regarding 7b, Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan. There are concerns regarding numerical writing conventions. On page 32, the Results Table 2, Yr. 1, Indicator #1, a miscalculation was identified, the numerator exhibits as 7.988, with a denominator 32,617, yielding a rate of 24.49%. However, the numerator should be reflective 7,988 which would align with the outcome rate for accuracy of the calculation. On page 34, Results Table 2 Indicator #1, a miscalculation was identified, numerator 2,753/ denominator 11,490 should reflect the rate of 23.96%. The Baseline for Southern Jersey Family Medical Centers, and Rutgers RWJ Eric B Chandler Health Ctr. percentage should be zero % as the denominator has a numerical value, review for accuracy. On pages 38-39 there are multiple calculations noting 0 numerator/ numerical denominator yielding NA for a result which is an inaccurate result. If the numerator is zero and the denominator contains a numerical value, then the result should be zero percent (Ex: 0/2860=0.00%) The MCO should review all calculations throughout the PIP for accuracy and consistent numeric writing.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that a healthcare disparity is not addressed.
Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70.0 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Concerns were identified with aspects of the numerical writing conventions regarding calculations. The MCO has made noteworthy changes due to 2 providers withdrawing from participating in the PIP in the third fourth quarter of 2021 leaving 4 of 6 providers in 2021. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that is demonstrative of the intended impact on performance outcomes.

HNJH PIP 3: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

MCO Name: Horizon New Jersey Health

PIP Topic 3: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**M**			
Element 3 Overall Score	**N/A**	**100**	0	0	0
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			
	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**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**0%**	**0%**	**0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
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 compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is complaint.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase. Element 9 Overall Review Determination was that the MCO is reviewing data to address potential barriers/disparities regarding access to where HNJH members receive immunizations.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made comprehensive updates to the PIP noting successes and limitations. Most notable Barrier identified is the acquisition of data that would accurately inform of initial goals and shed light on potential disparities that may present obstacles to where members receive immunizations. The MCO continues to actively pursue the data capture to remedy any obstacles that may prevent members access to receiving immunizations and update in the April 2023 Update submission. The MCO should review the cover page to include the page information on page 1 of the PIP. The MCO should continue to update as changes occur documenting the changes in the respective sections over the life of the PIP.

HNJH PIP 4: Reducing admissions, readmissions and gaps in services for members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 4: Reducing Admissions, Readmissions and Gaps in Services for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	N/A	**M**	**M**	**M**	**M**
Element 3 Overall Score	N/A	**100**	**100**	**100**	**100**
Element 3 Weighted Score	N/A	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	N/A	**M**	**M**	**M**	**M**
Element 4 Overall Score	N/A	**100**	**100**	**100**	**100**
Element 4 Weighted Score	N/A	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	N/A	M	M
Element 5 Overall Review Determination	N/A	**M**	**N/A**	**M**	**M**
Element 5 Overall Score	N/A	**100**	**0**	**100**	**100**
Element 5 Weighted Score	N/A	**15.0**	**0.0**	**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	N/A	M	M	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**

Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	PM	PM	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**	**PM**	**M**
Element 7 Overall Score	**N/A**	**0**	**50**	**50**	**100**
Element 7 Weighted Score	**N/A**	**0.0**	**10.0**	**10.0**	**20**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	PM
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**PM**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**50**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **(Y=Yes N=No)**	**N/A**	N	N	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**55.0**	**90.0**	**90.0**
Overall Rating	**N/A**	**100%**	**84.6%**	**90.0%**	**90.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Report Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination is that the MCO is compliant.

Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination is that the MCO is compliant.
Element 8 Overall Review Determination is that the MCO is partially compliant regarding 8b, Sustained improvement was demonstrated through repeated measurements over comparable time periods. The MCO has clearly reviewed the data during the Sustainability Year noted on Table 2-Results, however, did not include quarterly tracking measures for that timeframe. The Sustainability Year allows the reader as well as the MCO to finalize what interventions made progress and what interventions are sustainable and/or reasonable for the MCO to expand to the larger membership over time.
Element 9 Overall Review Determination is that the MCO did not address a healthcare disparity.

Overall, the MCO is compliant with this PIP for Sustainability; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has incorporated feedback appropriately and continues to monitor the progress of the PIP despite the impact of the Covid-19 pandemic. The MCO has made progress and continues to refine processes to improve the quality of the project to benefit the members. The MCO has added additional tables with data to explain and demonstrate Covid-19 impact to the members, thereby affecting interventions of the PIP as well as increased meeting and collaboration with the teams monthly provided discussion for problem solving and education. The MLTSS team devised a CHF training that was successfully implemented over a 6-week period. One constant limitation noted continues to be the impact that Covid-19 has on all populations, although the MCO teams are continuing to pursue the PIP goals. Although the MCO did not meet the Long-Term Goals set, the progress made was significant.

HNJH PIP 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

MCO Name: Horizon New Jersey Health
PIP Topic 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					

2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	N/A	**M**			
Element 3 Overall Score	N/A	**100**	0	0	0
Element 3 Weighted Score	N/A	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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	Y			
	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%**	**0.0%**	**0.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: Horizon New Jersey Health
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 18, 2022
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 compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant 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). On page 25, Table 1a2 does not appear to correspond with Intervention #1. This ITM should be reviewed for inclusion with rational or removed. Additionally, the numbering convention is difficult to follow as there is only 1 ITM with corresponding with each Intervention. The MCO should consider 1a, 1b, 1c, 2a, 2b etc. for numbering and remove the additional numbers 1a1, 1a2, etc. for reader clarity and ease.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that Healthcare Disparities have been assessed, based on race/ethnicity and sex, and identified White males(14/52) and determined due to the small number not to proceed at this time.
Overall, the MCO was 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 90.6% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has made comprehensive overview of the changes and updates, review of progress and/or limitations of each intervention. The MCO acknowledges success with increased communication and collaboration of internal teams working together identifying areas of improvement and acknowledges positive movement towards the goals of the PIP. One limitation noted was that the MCO may not always receive an authorization for the inpatient stay for which the MCO would not have notice timely. The MCO should continue to review, adjust, and document as changes occur, updating in the April and August 2023 submissions.

HNJH – HEDIS Audit Review Table MY 2021

Audit Review Table					
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health (Org ID: 6610, Sub ID: 7459, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2021; Date & Timestamp - 6/10/2022 12:50:52 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		87.5%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		83.84%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.57%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		73.24%	R	R	Reported
Childhood Immunization Status - IPV		88.08%	R	R	Reported
Childhood Immunization Status - MMR		83.45%	R	R	Reported
Childhood Immunization Status - HiB		86.37%	R	R	Reported
Childhood Immunization Status - Hepatitis B		86.86%	R	R	Reported
Childhood Immunization Status - VZV		84.67%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		67.15%	R	R	Reported
Childhood Immunization Status - Hepatitis A		74.94%	R	R	Reported
Childhood Immunization Status - Rotavirus		61.31%	R	R	Reported
Childhood Immunization Status - Influenza		49.64%	R	R	Reported
Childhood Immunization Status - Combo 3		59.37%	R	R	Reported
Childhood Immunization Status - Combo 7		45.26%	R	R	Reported
Childhood Immunization Status - Combo 10		33.33%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		87.31%	R	R	Reported
Immunizations for Adolescents - Tdap		90.4%	R	R	Reported
Immunizations for Adolescents - HPV		34.01%	R	R	Reported
Immunizations for Adolescents - Combination 1		86.28%	R	R	Reported
Immunizations for Adolescents - Combination 2		32.32%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		62.57%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		54.32%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		57.79%	R	R	Reported
Chlamydia Screening in Women (CHL)					

Chlamydia Screening in Women (16-20)		55.32%	R	R	Reported
Chlamydia Screening in Women (21-24)		65.1%	R	R	Reported
Chlamydia Screening in Women (Total)		59.97%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (3-17)		53.75%	R	R	Reported
Appropriate Testing for Pharyngitis (18-64)		32.82%	R	R	Reported
Appropriate Testing for Pharyngitis (65+)		18.5%	R	R	Reported
Appropriate Testing for Pharyngitis (Total)		43.7%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		30.97%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		72.68%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		88.81%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (5-11)		78.97%	R	R	Reported
Asthma Medication Ratio (12-18)		71.46%	R	R	Reported
Asthma Medication Ratio (19-50)		65.78%	R	R	Reported
Asthma Medication Ratio (51-64)		65.02%	R	R	Reported
Asthma Medication Ratio (Total)		68.41%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		62.59%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		85.37%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (M 21-75)		84.04%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (M 21-75)		76.45%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (F 40-75)		79.96%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (F 40-75)		76.82%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		82.29%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		76.61%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (18-64)		1.13%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (18-64)		2.11%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (18-64)		2.35%	R	R	Reported

Cardiac Rehabilitation - Achievement (18-64)		0.64%	R	R	Reported
Cardiac Rehabilitation - Initiation (65+)		1.02%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (65+)		2.04%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (65+)		3.06%	R	R	Reported
Cardiac Rehabilitation - Achievement (65+)		0%	R	R	Reported
Cardiac Rehabilitation - Initiation (Total)		1.12%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		2.1%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		2.38%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.61%	R	R	Reported
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing		85.4%	R	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		33.09%	R	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		58.39%	R	R	Reported
Comprehensive Diabetes Care - Eye Exams		54.5%	R	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		64.23%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (18-64)		13.15%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (65-74)		15.6%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (75-85)		15.74%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (Total)		13.41%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		68.96%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		70.02%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		59.97%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		46.76%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		29.79%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		34.9%	R	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (6-17)		48.65%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (6-17)		18.92%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (18-64)		47.51%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (18-64)		28.35%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (65+)		45.1%	R	R	Reported

Follow-Up After Hospitalization For Mental Illness - 7 days (65+)		11.76%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		47.33%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		25.8%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (6-17)		74.53%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (6-17)		65.66%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (18-64)		63.36%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (18-64)		55.44%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (65+)		67.92%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (65+)		58.49%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		67.69%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		59.39%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)		28.57%	NA	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)		0%	NA	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)		47.48%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)		26.76%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)		9.76%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)		2.44%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		47.12%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		26.51%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (13-17)		13.4%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (13-17)		9.28%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (18+)		25.33%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (18+)		17.37%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		25.09%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		17.2%	R	R	Reported

Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (16-64)		26.58%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (65+)		41.46%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (Total)		26.71%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Med (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		79.34%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		69.3%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		74.67%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		67.09%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (1-11)		28.6%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (1-11)		27.68%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (1-11)		19.45%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (12-17)		49.2%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (12-17)		41.54%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (12-17)		32.92%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		42.49%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		37.03%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		28.54%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.22%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (3 Months-17 Years)		93.49%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (18-64)		64.02%	R	R	Reported

Appropriate Treatment for Upper Respiratory Infection (65+)		57%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (Total)		86.24%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months-17 Years)		57.34%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)		40.1%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (65+)		48.34%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		48.73%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain		76.47%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		12.24%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		18.36%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.8%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.91%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (18-64)		5.73%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (18-64)		3.6%	R	R	Reported
Risk of Continued Opioid Use - >=15 Days (65+)		13.07%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (65+)		6.4%	R	R	Reported
Risk of Continued Opioid Use - >=15 Days (Total)		5.92%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		3.68%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (20-44)		79.53%	R	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (45-64)		87.34%	R	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (65+)		92.23%	R	R	Reported
Adults' Access to Preventive/Ambulatory Health Services (Total)		82.72%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (2-3)		41.74%	R	R	Reported
Annual Dental Visit (4-6)		60.2%	R	R	Reported
Annual Dental Visit (7-10)		64.36%	R	R	Reported
Annual Dental Visit (11-14)		62.03%	R	R	Reported
Annual Dental Visit (15-18)		55.87%	R	R	Reported
Annual Dental Visit (19-20)		42.13%	R	R	Reported
Annual Dental Visit (Total)		57.2%	R	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (13-17)			NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (13-17)			NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (13-17)			NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (13-17)			NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (13-17)		100%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (13-17)		100%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (13-17)		100%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (13-17)		100%	NA	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (18+)		46.05%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (18+)		6.51%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (18+)		47.13%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (18+)		18.47%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (18+)		46.55%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (18+)		9.48%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (18+)		45.15%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (18+)		11.19%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence		46.05%	R	R	Reported

Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)					
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		6.51%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		47.13%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		18.47%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		46.7%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		9.74%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		45.21%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		11.28%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		83.62%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		80.75%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (1-11)		58.73%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (12-17)		69.11%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		65.57%	R	R	Reported
Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		52.17%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		70.26%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (3-11)		67.1%	R	R	Reported
Child and Adolescent Well-Care Visits (12-17)		62.49%	R	R	Reported
Child and Adolescent Well-Care Visits (18-21)		38.71%	R	R	Reported
Child and Adolescent Well-Care Visits (Total)		60.85%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMBa)			R	R	Reported

Ambulatory Care (AMBb)			R	R	Reported
Ambulatory Care (AMBc)			R	R	Reported
Ambulatory Care (AMBd)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUb)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUc)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUd)			R	R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	R	Reported
Identification of Alcohol and other Drug Services (IADb)	Y		R	R	Reported
Identification of Alcohol and other Drug Services (IADc)	Y		R	R	Reported
Identification of Alcohol and other Drug Services (IADd)	Y		R	R	Reported
Mental Health Utilization (MPTa)	Y		R	R	Reported
Mental Health Utilization (MPTb)	Y		R	R	Reported
Mental Health Utilization (MPTc)	Y		R	R	Reported
Mental Health Utilization (MPTd)	Y		R	R	Reported
Antibiotic Utilization (ABXa)	Y		R	R	Reported
Antibiotic Utilization (ABXb)	Y		R	R	Reported
Antibiotic Utilization (ABXc)	Y		R	R	Reported
Antibiotic Utilization (ABXd)	Y		R	R	Reported
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENPa)			R	R	Reported
Enrollment by Product Line (ENPb)			R	R	Reported
Enrollment by Product Line (ENPc)			R	R	Reported
Enrollment by Product Line (ENPd)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Electronic Clinical Data Systems					
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening			NR	NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)					
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase			NR	NR	Not Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase			NR	NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)			NR	NR	Not Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NR	NR	Not Reported

Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)			NR	NR	Not Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NR	NR	Not Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NR	NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)			NR	NR	Not Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NR	NR	Not Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza			NR	NR	Not Reported
Adult Immunization Status - Td/Tdap			NR	NR	Not Reported
Adult Immunization Status - Zoster			NR	NR	Not Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		18.46%	R	R	Reported
Prenatal Immunization Status - Tdap		35.97%	R	R	Reported
Prenatal Immunization Status - Combination		12.5%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening			NR	NR	Not Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	NR	Not Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening			NR	NR	Not Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NR	NR	Not Reported

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2022 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	26	30	22	22	8	0	73%	4	0	4
Care Management and Continuity of Care - MLTSS*	10	7	10	10	10	0	0	100%	0	3	0
Access	14	11	14	10	10	4	0	71%	3	0	1
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[5]	21	18	21	20	20	1	0	95%	1	1	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	39	44	43	43	1	0	98%	0	5	1
Provider Training and Performance	11	11	11	10	10	1	0	91%	0	0	1
Satisfaction	5	5	5	5	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	9	10	10	10	0	0	100%	0	1	0
Utilization Management	30	28	30	28	28	0	2	100%	0	0	0
Administration and Operations	14	14	14	14	14	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	18	0	0	100%	0	0	0
TOTAL	**199**	**185**	**199**	**190**	**190**	**7**	**2**	**96%**	**4**	**7**	**3**

[1] A total of 86 elements were reviewed in the previous review period; of these 86, 73 were *Met*, 11 were *Not Met;* 2 were *N/A.* Remaining existing elements that were *Met Prior Year* were deemed *Met* in the previous review period.

[2] The MCO was subject to a full review in this review period. All elements were subject to review.

[3] Elements that were *Met* in this review period.

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

[5] QM20 was added as a new element in 2022.

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

UHCCP Performance Improvement Projects

UHCCP PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	PM	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 3 Overall Score	**N/A**	**50.0**	**100**	**100**	**100**
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	M	M
Element 5 Overall Review Determination	N/A	**PM**	**N/A**	**M**	**M**
Element 5 Overall Score	**N/A**	**50.0**	**N/A**	**100**	**100**
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**	**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	N/A	M	M	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65**	**100**	**100**
Actual Weighted Total Score	**N/A**	**45.0**	**65.0**	**100.0**	**100.0**
Overall Rating	**N/A**	**75.0%**	**100.0%**	**100.0%**	**100.0%**

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

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: UnitedHealthcare Community Plan
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 22, 2022
Report Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO was compliant.
Element 2 Overall Review Determination was that the MCO was compliant.
Element 3 Overall Review Determination was that the MCO was compliant.
Element 4 Overall Review Determination was that the MCO was compliant.
Element 5 Overall Review Determination was that the MCO was compliant.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was that the MCO was compliant.
Element 9 Overall Review Determination was that Healthcare Disparities were not addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO continued to conduct medical record reviews year over year throughout the life of the PIP, reviewing the results, discussing with providers, and adjusting as needed dependent on the results of each audit. The MCO has updated and included PIP information as well as any changes or updates with complete and comprehensive details for ease of reading and understanding each phase of this PIP. The MCO discusses the barriers during the COVID-19 virus in 2020 and 2021 regarding the impact to the members, providers as well as work arounds to outreach the membership. Telehealth was one tool used to provide virtual visits although during these visits the adolescent risk behavior discussions were not always able to be completed as parents were often in the room and did not provide the same level of privacy to discuss issues as pre-Covid-19 office visits. The MCO identified success factors which include quarterly meetings with the quality team to provide staff support and education reinforcing risk screening rates, remain engaged, utilized provider reports to outreach members, provided handouts and educational materials for the providers and members for all provider participants. Limitations were also identified such as medical record review may have fallen off the mark for risk screenings which could occur during a Telehealth visit, and at least one provider did not see a comparable increase in the rate of member positive responses as expected due to the significant increase in screening rates. The MCO discussed in detail Lessons Learned over the life of the PIP, successes, and limitations as well as explanations for discontinuing or changes made in interventions as well as newly implemented barriers /interventions. The MCO recognizes that a multifaceted approach toward common goals is beneficial to all parties engaged in the project. The MCO has provided a clear and comprehensive assessment of the PIP and understands the benefit to the members which can be applied to additional providers within the MCO network as applicable. Although not all long-term goals may have been achieved, many goals either met or exceeded the target goal concluding a successful project.

UHCCP PIP 2: Decrease Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical)

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 2: Increasing PCP Access and Availability for Members with Low Acuity, Non-emergent ED Visits- Core Medicaid Membership

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 (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	PM	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M		
Element 1 Overall Review Determination	**N/A**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 1 Weighted Score	**N/A**	**2.5**	**5.0**	**0.0**	**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	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
3b. Performance indicators are measured consistently over time	N/A	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M		

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**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	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M		
4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**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	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M		
Element 5 Overall Review Determination	**N/A**	**M**	**M**		
Element 5 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**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	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**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	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**	**N**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**80.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**96.9%**	**100%**	**0%**	**0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: UnitedHealthcare Community Plan
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
Reporting Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.

Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that 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 80.0 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO continues to review each section of the PIP, adjusting data and/or information as changes arise. The MCO has met with the providers throughout the 2021 MY discussing findings of the interventions as related to opportunities decrease emergency room use for potential PCP visits. The providers are understanding via a survey conducted of the membership population using the ER for sick visits boil down to the following across all three providers, feeling very sick/thought they had COVID-19 and self-referred to ER, member outreached PCP and was referred to ER, member was feeling very sick and appointment was "too far out" and member was sick on the weekend /after hours and self-referred to ER. One provider is being acquired by RWJ Barnabas Health by the end of 2022. The MCO was noted to have one (1) miscalculation on page 34, Yr1, Indicator 1, 2753/11490=24.93%is inaccurate. The MCO should review for accuracy. The MCO continues to progress toward the goals of the PIP and has begun to see signs of success regarding positive outcomes.

UHCCP PIP 3: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

MCO Name: United Healthcare Community Plan (UHCCP)
PIP Topic 3: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**M**			
Element 3 Overall Score	**N/A**	**100**	0	0	0
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					

5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			
	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**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: UnitedHealthcare Community Plan
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
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 compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is complaint.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that the MCO is monitoring for healthcare disparities data to address.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made comprehensive updates to the PIP noting successes and limitations. The MCO has successfully implemented a Care Management referral process for members who express concerns related to Social Determinants of Health (SDOH), as well as developed processes to assure monthly communications with the leadership team at each targeted provider office assuring well visits and education to members regarding immunizations. Additionally, the MCO identified limitations with one provider that exhibits significant turnover with office management staff and find it difficult to engage and educate new staff. The MCO should continue to update as changes occur documenting the changes in the respective sections over the life of the PIP.

UHCCP PIP 4: Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 4: Improving Influenza and Pneumococcal Immunization Rates and Timely Personal Care Assistant (PCA) Service in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	PM	PM	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	N/A	**M**	**PM**	**PM**	**M**
Element 3 Overall Score	N/A	**100**	**50**	**50**	**100**
Element 3 Weighted Score	N/A	**15.0**	**7.5**	**7.5**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	N/A	M	M
5b. Actions that target member, provider and MCO	N/A	M	N/A	M	M
5c. New or enhanced, starting after baseline year	N/A	M	N/A	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	N/A	PM	M
Element 5 Overall Review Determination	N/A	**PM**	**N/A**	**PM**	**M**
Element 5 Overall Score	N/A	**50.0**	**0**	**50**	**100**
Element 5 Weighted Score	N/A	**7.5**	**0**	**7.5**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	M	M	M
Element 6 Overall Review Determination	**N/A**	**PM**	**M**	**M**	**M**
Element 6 Overall Score	**N/A**	**50**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**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.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	M
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N/A	**N**	**N**	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55.0**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**0**	**47.5**	**52.5**	**85.0**	**100.0**
Overall Rating	**0%**	**79.2%**	**80.8%**	**85.0%**	**100.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: UnitedHealthcare Community Plan
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org
Date (report submission) reviewed: October 20, 2022
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination is that the MCO is compliant.
Element 2 Overall Review Determination is that the MCO is compliant.
Element 3 Overall Review Determination is that the MCO is compliant.
Element 4 Overall Review Determination is that the MCO is compliant.
Element 5 Overall Review Determination is that the MCO is compliant.
Element 6 Overall Review Determination is that the MCO is compliant.

Element 7 Overall Review Determination is that the MCO is compliant.
Element 8 Overall Review Determination is that the MCO is compliant.
Element 9 Overall Review Determination is that this PIP does not address Healthcare Disparities.

Overall, the MCO is compliant with this PIP for Sustainability Year reporting requirement; out of a maximum possible weighted score of 100 points, the MCO scored 100.0 points, which results in a rating of 100.0% (which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has 2-sections of this PIP. Firstly, Improving Flu and Pneumococcal Immunization made progress towards the Long-Term Goals, noting that the Covid-19 Pandemic was an intervening factor as the NJ Choice was the initial way of collecting the data to support this project. The MCO reviewed alternatives to this method of data capture as the Face-to-Face visits restarted. The MCO will continue to educate and ask members about the Flu and Pneumonia Vaccination status as well as adding in Covid-19 vaccine during quarterly visits/interactions. Secondly, regarding timely PCA Services in the MLTSS HCBS population, also was noted to make some strides toward the Long-Term Goal although the Covid -19 had an impact on providing services to the members. The MCO identified that concerns were first scheduling PCA services when the member needs them when no services are available due to the pandemic. Secondly, also identified many members made the choice of PPP where a family member who was familiar with the members situation and needs could be available to provide the service. While the PI did not meet the LT Goal, the MCO did improve in turnaround time for administrative work, collaboration with more PCA providers and plan on tracking timeliness of PCA services as well as PPP services for members that qualify. The MCO should note one cavate for future projects, the Abstract instructions call for 2-page Summary of the PIP (the MCO provided 5pgs.) and could refer to areas for the complete information contained in the Abstract.

UHCCP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: New Jersey UnitedHealthcare Community Plan (NJUHCCP)
PIP Topic 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	N/A	**M**			
Element 3 Overall Score	N/A	**100**	0	0	0
Element 3 Weighted Score	N/A	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**0.0%**	**0.0%**	**0.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: UnitedHealthcare Community Plan
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October18, 2022
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 compliant.
Element 4 Overall Review Determination was that the MCO is partially compliant regarding QI Process 4d, a concern was identified with aspects of the Barrier Analysis, Interventions, and Monitoring Table 1a, which is out of alignment. The MCO should review to ensure that the correct version of the PIP Template is in use. Additionally, the MCO has changed Termed Intervention 1b and added 2c as new for Barrier Intervention 2.

Barrier Intervention 2a, was renamed 2b and renamed 2a with a new Barrier Intervention. Interventions should not be renamed; they should be terminated, and the number should not be used as this is confusing when evaluating the progress of interventions over the life of the PIP. The MCO should correct the numbering of the Barrier and corresponding ITMs in Table 1b to ensure an accurate and comprehensive evaluation of Interventions/ITMs over the life of the PIP.
Element 5 Overall Review Determination was that the MCO is partially compliant 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). Table 1 Quarterly Reporting for Intervention Tracking Measures, pages 29-39 do not appear to be in the correct version of the PIP Template, noting Numerator /Denominator/Rate are written out as in the present PIP Template Numerator/Denominator and Rate are shown as N: D: R: throughout each page. Additionally, Intervention 2a Q1 2022, exhibits N:NA/ D:NA and Rate: states Intervention begin on 7/1/2022. The MCO should note NA for the Rate as well and footnote the explanation at the bottom of Table 1b. Interventions/ITMs 5a and 6a are also noted to exhibit the same writing conventions. The MCO should update to the current version of the PIP Template as well as update the interventions noted and add footnotes for each.
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 is that Healthcare disparities have been reviewed, evaluated and are being addressed.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible have weighted score of 80.0 points the MCO scored 65.0points, which results in a rating of 81.3% (Which is below 86% [≥ 86% being the threshold for meeting compliance]). MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2023 submissions.

UHCCP – HEDIS Audit Review Table MY 2021

Audit Review Table					
AmeriChoice of New Jersey, Inc. dba UnitedHealthcare Community Plan (NJ) (Org ID: 1995, Sub ID: 8004, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2021; Date & Timestamp - 6/12/2022 6:43:00 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		86.37%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		83.21%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.81%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		63.26%	R	R	Reported

Childhood Immunization Status - IPV		76.64%	R	R	Reported
Childhood Immunization Status - MMR		77.13%	R	R	Reported
Childhood Immunization Status - HiB		78.59%	R	R	Reported
Childhood Immunization Status - Hepatitis B		75.67%	R	R	Reported
Childhood Immunization Status - VZV		76.64%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		59.37%	R	R	Reported
Childhood Immunization Status - Hepatitis A		67.88%	R	R	Reported
Childhood Immunization Status - Rotavirus		56.45%	R	R	Reported
Childhood Immunization Status - Influenza		47.2%	R	R	Reported
Childhood Immunization Status - Combo 3		52.8%	R	R	Reported
Childhood Immunization Status - Combo 7		41.85%	R	R	Reported
Childhood Immunization Status - Combo 10		30.9%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		89.78%	R	R	Reported
Immunizations for Adolescents - Tdap		92.7%	R	R	Reported
Immunizations for Adolescents - HPV		34.55%	R	R	Reported
Immunizations for Adolescents - Combination 1		87.83%	R	R	Reported
Immunizations for Adolescents - Combination 2		31.39%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		70.56%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		57.94%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		62.53%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		62.97%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		73.1%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		35.02%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		70.42%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		86.21%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		60.74%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		61.8%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		85.88%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				

Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		80.83%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		77.42%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		0.79%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		2.23%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		2.76%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		1.57%	R	R	Reported
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing		87.35%	R	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		35.52%	R	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		58.39%	R	R	Reported
Comprehensive Diabetes Care - Eye Exams		60.83%	R	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		62.04%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		34.78%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		70.86%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		71.79%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		65.51%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		47.87%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		32.08%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		39.6%	R	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		50.31%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		31.03%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		63.04%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		54.98%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		42.22%	R	R	Reported

Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		18.4%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		18.48%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		12.9%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		26.8%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		85.95%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		75.04%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		81.05%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		69.54%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		60.21%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		44.76%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		43.46%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.43%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		85.34%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		53.51%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain		78.4%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.2%	R	R	Reported

Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		12.7%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.25%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.61%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		7.49%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.58%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		85.02%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (Total)		62.92%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		43.56%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		6.14%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		51.46%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		24.85%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		44.44%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		5.13%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		44.82%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		11.55%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		83.45%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		80.05%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		60.13%	R	R	Reported

Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		52.03%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		70.25%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		60.75%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMBa)			R	R	Reported
Ambulatory Care (Dual) (AMBb)			R	R	Reported
Ambulatory Care (Disabled) (AMBc)			R	R	Reported
Ambulatory Care (Low Income) (AMBd)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Dual) (IPUb)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Disabled) (IPUc)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Low Income) (IPUd)			R	R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Dual) (IADb)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Disabled) (IADc)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Low Income) (IADd)	Y		R	R	Reported
Mental Health Utilization (MPTa)	Y		R	R	Reported
Mental Health Utilization (Dual) (MPTb)	Y		R	R	Reported
Mental Health Utilization (Disabled) (MPTc)	Y		R	R	Reported
Mental Health Utilization (Low Income) (MPTd)	Y		R	R	Reported
Antibiotic Utilization (ABXa)	Y		R	R	Reported
Antibiotic Utilization (Dual) (ABXb)	Y		R	R	Reported
Antibiotic Utilization (Disabled) (ABXc)	Y		R	R	Reported
Antibiotic Utilization (Low Income) (ABXd)	Y		R	R	Reported
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENPa)			R	R	Reported
Enrollment by Product Line (Dual) (ENPb)			R	R	Reported
Enrollment by Product Line (Disabled) (ENPc)			R	R	Reported
Enrollment by Product Line (Low Income) (ENPd)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Electronic Clinical Data Systems					
Breast Cancer Screening (BCS-E)					

Breast Cancer Screening		57.79%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		32.02%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		39.6%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0.01%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0.01%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.01%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza		21.19%	R	R	Reported
Adult Immunization Status - Td/Tdap		24.99%	R	R	Reported
Adult Immunization Status - Zoster		5.31%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		20.16%	R	R	Reported
Prenatal Immunization Status - Tdap		31.5%	R	R	Reported
Prenatal Immunization Status - Combination		12.61%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported

Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

WCHP 2022 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Care Management and Continuity of Care – Core Medicaid*	30	27	30	24	24	6	0	80%	3	0	3
Care Management and Continuity of Care - MLTSS*	10	10	10	10	10	0	0	100%	0	0	0
Access	14	12	10	11	11	3	0	79%	2	0	1
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management[6]	21	18	12	20	20	1	0	95%	0	2	1
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	12	44	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	11	11	0	0	100%	0	0	0
Satisfaction	5	5	3	5	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	8	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	9	9	1	0	90%	0	0	0
Utilization Management	30	28	14	30	30	0	0	100%	0	1	0
Administration and Operations	14	14	4	13	13	1	0	93%	0	0	1
Management Information Systems	18	18	3	18	18	0	0	100%	0	0	0
TOTAL	**199**	**192**	**93**	**193**	**193**	**6**	**0**	**97%**	**2**	**3**	**3**

[1] All existing elements were subject to review in the previous review period.
[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.
[3] Elements that were *Met* in this review period among those that were subject to review.
[4] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.
[5] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.
[6] QM20 was added as a new element in 2022.
*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Corrective Action Plans (CAPs) as applicable.

WCHP Performance Improvement Projects

WCHP PIP 1: MCO Adolescent Risk Behaviors and Depression Collaborative

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)

PIP Topic 1: MCO Adolescent Risk Behaviors and Depression Collaborative

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

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

Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	M	PM
Element 7 Overall Review Determination	**N/A**	**N/A**	**M**	**M**	**PM**
Element 7 Overall Score	**N/A**	**N/A**	**100**	**100**	**50**
Element 7 Weighted Score	**N/A**	**N/A**	**20.0**	**20.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**52.5**	**57.5**	**85.0**	**80.0**
Overall Rating	**N/A**	**87.5%**	**88.5%**	**85.0%**	**80.0%**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Phase)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: WellCare Health Plans of New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 22, 2022
Report Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is partially compliant regarding 1a, Project Identifiers Completed. On page 2-3, bullet 4, For Update and Final Reports. The MCO has identified a significant change to the PIP in the second quarter of 2022 (page 79) which resulted in limited contact with the group providers and office staff. In the Final Report all changes and updates made should have been identified on the Change Table (pages 2-3) for accuracy. The disengagement of a provider is a notable change which

should have be documented on the Change Table for effective tracking over the life of the PIP and a comprehensive evaluation.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is partially compliant regarding Robust Interventions, 5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). The MCO's PIP focus stated in the Aim Statement, "By 2021 the MCO aims to increase the percentage of medical record documentation for health risk behaviors and depression screening among adolescents aged 12-21 that had an adolescent well care visit (AWC)." The MCO has identified two (2) areas that did not meet the expectations regarding positive screening in sexual behaviors for Chlamydia testing and Depression Screenings - Clinical Response in all practices (33 positive screens of which 19 did not exhibit any follow up and three (3) female members were not evaluated for Chlamydia in the SY). Although the MCO has identified these concerns, the MCO has not implemented additional robust interventions/ITMs to remedy this concern. On page 75, the MCO identifies Quality Practice Advisors assigned to the providers have not engaged this group to assist in moving the rates regarding positive screening for both Chlamydia Testing and Clinical response to positive Depression screenings. The MCO should review for any opportunity to improve rates impacting the members affected and document the results of their efforts.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is partially compliant regarding 7d. Lessons learned & follow-up activities planned as a result. The MCO has made strides in the Aim and Goals of the PIP. However, the MCO could have expanded on Lessons Learned and the follow up activities over the life of the PIP, not just at the end. There were opportunities not initiated as noted above in Element 5, after the proposal except for educational information for providers to hand out and discuss with members where the MCO could have expanded interventions each measurement year as noted in the Table 6- Results in regarding to Depression screenings, Clinical Responses. The MCO should review each measurement year for lessons and opportunities for additional interventions to improve outcomes.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that the MCO did not address a healthcare disparity.

Overall, the MCO is partially compliant with this PIP for the Final Report requirement; out of a maximum possible weighted score of 100.0 points, the MCO scored 80.0 points, which results in a rating of 80.0% (which is below the 85% [≥ 85% being the threshold for meeting compliance]). Overall, the MCO made strides towards the goals and although not all goals were met, many came close, and some exceeded. The MCO continued to outreach providers throughout the Covid-19 virus, adjusting where possible to maintain processes with the providers participating in the PIP. Two (2) of the three (3) providers remained engaged, however, the third provider closed the facility during quarter two of 2020, and did not reopen until the third quarter of 2021. During this timeframe, the MCO was unable to engage with the provider. Upon re-establishing communication, this provider did not re-engage in the PIP. Having only two providers posed limitations, however the MCO continued with the two providers and continued to make strides with both providers. The MCO will take next steps by making recommendations to expand education of Risk Behaviors and Depression Screenings to pediatric providers and assist in creating processes to allow opportunities for truthful information between member and provider without parental attendance as this has been an identified barrier. Additionally, the Abstract, Section Two (2) instructions was not to exceed two (2) pages, however the Abstract contains five (5) pages which did include documentation in Section 7, discussion as well as updates to each measurement year making the length of the Abstract long as well as data driven rather than a summary of the PIP.

WCHP PIP 2: Medicaid Primary Care Physician Access and Availability

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)
PIP Topic 2: Medicaid Primary Care Physician Access and Availability

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M	M		
1b. Impacts the maximum proportion of members that is feasible	N/A	M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	M	M		
1d. Reflects high-volume or high risk-conditions	N/A	M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 1 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	M	M		
2c. Objectives align aim and goals with interventions	N/A	M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	PM	M		
3b. Performance indicators are measured consistently over time	N/A	M	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M		

3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**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	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M		
4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**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	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	PM		
Element 5 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**7.5**	**0.0**	**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	M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**0.0**	**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	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**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	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**	**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**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**90.6%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: WellCare Health Plans of New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
Reporting Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was partially compliant regarding 5d, with corresponding monthly or quarterly intervention tracking measures. In Table 1a (Alignment of Barriers, Interventions, and Intervention Tracking Measures [ITMs]). On page 28, Results Table 2, regarding Indicators #3 and #4, the calculations should be displayed in a rate percentage format. The footnotes do not fully explain how the MCO calculates numerator/ denominator equaling visits/1000 when the calculation for the rates is displayed as N/D *1200 as

noted in footnote ***, however, the asterisk (***) is not identified on any of the calculations regarding Indicators #3 and #4. For example, Baseline rate 19,295/66103 can yield 291.90% if visits/1000 is used as the calculation versus 19,295/66103 can yield 350.27% or 350.30% depending on rounding the decimal using the N/D times 1200. The MCO should provide the rates and not visits/1000 below the calculation, as this is confusing. The MCO should provide clarifications to the footnotes cited below Table 2 for Indicators #3 and #4 as well as in the Data Collection and Analysis Procedures section.
Element 6 Overall Review Determination was that the MCO was compliant.
Element 7 Overall Review Determination was that the MCO was compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that the MCO did not address health disparities.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 65.0 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). MCO should ensure that when initiating changes and/or updates to the Barrier Analysis Table 1a, Start and End dates are included (For example: 1c-1ciii should reflect dates for each ITM). The alignment between Barrier Analysis, Table 1a and Quarterly Reporting, Table 1b should flow consistently for reader ease, clarity, and accuracy of the PIP. Additionally, the MCO might consider what the top 5-10 LANE (Low Acuity Non-Emergent) diagnoses from the expansive Appendix D: NYU ER Algorithm for Diagnosis that may provide potential opportunities to educate both members and providers of what specific areas of disease may be treated effectively in the PCP office rather than the emergency room. The MCO should review the concerns noted above, update for the next submissions April and August of 2023.

WCHP PIP 3: Improving Early and Periodic Screening diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

MCO Name: WellCare Health Plan
PIP Topic 3: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

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 (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	N/A	M			
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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			

2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	PM			
2c. Objectives align aim and goals with interventions	N/A	M			
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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**PM**			
Element 3 Overall Score	**N/A**	**50**	0	0	0
Element 3 Weighted Score	**N/A**	**7.5**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (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	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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			

	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**	**60.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**75.0%**	**0.0%**	**0.0%**	**0.0%**

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

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: WellCare Health Plans of New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: November 2, 2022
IPRO Comments: Year 1
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is partially compliant regarding 2b, goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. The MCO continued to use Baseline data 2019 and did not update to the required 2021 Baseline noted in the June 2022 PIP Training. The rational for the change was due to the HEDIS Measure change during MY 2020 which expanded W-15 to W-30 including 0- 30 months of well child visits and immunizations requirements. The MCO should review all data, Aim Statements, Objective, Goals and update accordingly using the 2021 MY as the Baseline.
Element 3 Overall Review Determination was that the MCO was partially compliant regarding 3g, study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. During the 2022 Annual NJ MCO PIP Training, the baseline for EPSDT PIP instruction was "Please note for the EPSDT PIP, Baseline information for all MCO's should reflect MY 2021. HEDIS data will be available in June of 2022 and should be updated in the August 2022 Report Submission". The MCO should update baseline and respective corresponding data information for the April and August 2023 Updates.
Element 4 Overall Review Determination was the MCO was complaint.
Element 5 Overall Review Determination was that the MCO is partially compliant regarding Robust Interventions, 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). On page 23, Intervention/ITM 5a does not align with Barrier 5a and should be amended to reflect the correct numerator /denominator language as well as the document the Barrier Analysis Start and End dates. Table 1b exhibits multiple NAs throughout the Table, however has not footnoted the explanation regarding each NA status. The MCO should review all concerns and update data.
Element 6 Overall Review Determination was that the MCO is partially complaint regarding 6a, Table 2 shows Performance Indicator rates, numerators, and denominators, with corresponding goals. Although the calculations on page 26, Table 2 are correct, the 2019 Baseline, which should be 2021 and calls into question the validity of the Goal data presented. The MCO clearly notes the change in Methodology on page 31, August 2022 update, explains W-15 was retired and replaced with W-30 for 2021. The MCO should update the Baseline and verify the Goal data for Indicators #1 and #2. Additionally, Table 2a- Results, Indicator 1 noted different numerator /denominator and results, 250/588=42.52% which does not exhibit the overall rate (503/1496=33.62%) however, maintains the baseline as 2019 which should be 2021. The MCO should update the data to reflect the accurate baseline and related data.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that Healthcare disparities have been reviewed and addressed.
Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 60.0 points, which results in a rating of 75.0% (Which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant updates to the PIP, however much of the

PIP will need to be fully reviewed for accuracy due to not implementing the correct Baseline. Additionally, the MCO notes Barriers for providers such as language, not speaking the members language, no weekend or evening hours and no return calls after leaving message to schedule visit as well as multiple barriers for parents/guardians noting on page 32. The MCO should address the above concerns and barriers identified with clarifications or adjustments for a sufficiently developed PIP that is demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2023 submissions.

WCHP PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis

MCO Name: WellCare Health Plans of New Jersey, Inc. (WCHP)

PIP Topic 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	M
Element 3 Overall Review Determination	N/A	**M**	**M**	**M**	**M**
Element 3 Overall Score	N/A	**100**	**100**	**100**	**100**
Element 3 Weighted Score	N/A	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	M
4f. Literature review	N/A	M	M	M	M
Element 4 Overall Review Determination	N/A	**M**	**M**	**M**	**M**
Element 4 Overall Score	N/A	**100**	**100**	**100**	**100**
Element 4 Weighted Score	N/A	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	NA	M	M
5b. Actions that target member, provider and MCO	N/A	M	NA	M	M
5c. New or enhanced, starting after baseline year	N/A	M	NA	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	NA	M	M
Element 5 Overall Review Determination	N/A	**PM**	**NA**	**M**	**M**
Element 5 Overall Score	N/A	**50**	**NA**	**100**	**100**
Element 5 Weighted Score	N/A	**7.5**	**NA**	**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	N/A	M	M	M	M
Element 6 Overall Review Determination	N/A	**M**	M	**M**	**M**
Element 6 Overall Score	N/A	**100**	**100**	**100**	**100**
Element 6 Weighted Score	N/A	**5.0**	**5.0**	**5.0**	**5.0**

Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	M	PM	M
Element 7 Overall Review Determination	N/A	**N/A**	**M**	**PM**	**M**
Element 7 Overall Score	N/A	**0**	**100**	**50**	**100**
Element 7 Weighted Score	N/A	**0.0**	**20.0**	**10.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **(Y=Yes N=No)**	**N/A**	**N**	**N**	**N**	**N**
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**100**	**100**
Actual Weighted Total Score	**N/A**	**52.5**	**65.0**	**90.0**	**100**
Overall Rating	**N/A**	**87.5%**	**100.0%**	**90.0%**	**100.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan).
[1]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Findings Phase).

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: WellCare Health Plans of New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is compliant.

Element 5 Overall Review Determination was that the MCO is complaint.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was that the MCO is compliant.
Element 9 Overall Review Determination was that healthcare disparities was identified, evaluated, however not addressed as MCO identified that the data was skewed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100.0% (which is at or above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has aptly acknowledged data collection challenges over MY1 and MY2 due to the use of a manual process for tracking Care Management Activities and was being transitioned into electronic media thereby enhancing the data collection process for the Care Management Activities. Additionally, the MCO planned to implement a second cohort group for MY 2 however, was not able to pull the cohort together until 3rd quarter of 2021. The reasons for the delays are outlined within the limitations outside the control of the MCO such as Covid-19 Pandemic, Provider offices closing, face to face visits suspended, manual data tracking and members reporting honestly regarding symptoms of Sepsis. The MCO has chosen to continue as an internal tracking measure for comparison results. Although the MCO did not meet the Long-Term Goals, documentation of learned lessons and understanding barriers to decreasing inpatient stays for Sepsis were identified and will be researched further.

WCHP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: WellCare Health Plans of New Jersey, Inc.
PIP Topic 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

PIP Components and Subcomponents	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (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	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 (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	M			

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 (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	M			
3b. Performance indicators are measured consistently over time	N/A	M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	N/A	**M**			
Element 3 Overall Score	N/A	**100**	0	0	0
Element 3 Weighted Score	N/A	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
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 (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
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 (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M			
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 (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
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 (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
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**	**Y**			

	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**	**70.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**87.5%**	**0.0%**	**0.0%**	**0.0%**

≥ 86% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

New Jersey MCO PIP Report Checklist and Evaluation
MCO Name: WellCare Health Plans of New Jersey, Inc.
IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 18, 2022
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was the MCO is partially compliant regarding 1a, Attestation signed & Project Identifiers Completed. The MCO has signed the attestation however the date signed states 2021. The MCO should ensure all information is current and correct prior to submission.
Element 2 Overall Review Determination was that the MCO is complaint.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was that the MCO is partially compliant regarding 4d, QI Process data. The MCO notes changes to Barrier Interventions/ITMs for Barrier #2 and #4. Each of the barriers have Initial changes to Barrier #2 and Barrier #4. For example, Barrier #2, is new regarding numerator and denominator, and # 2a is a new barrier. Barrier #4 was changed by adding or face to face services, #4a is the initial #4 and #4d is new. The MCO should be aware of the importance of numbering on Tables 1a and 1b for corresponding ITM's. The MCO should terminate an intervention that is modified or changes the numerator /denominator as these changes the initial corresponding ITM on Table 1b. Maintaining the integrity of the numbering system is essential in providing an accurate and comprehensive evaluation of the progression of interventions and progress over the life of the PIP as well as prevents confusion. The MCO should review, and update documenting changes as noted on the Change Table on pages 2-3.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is complaint.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was that Healthcare disparities have been assessed and are being addressed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 70.0 points, which results in a rating of 87.5% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has reviewed the PIP and updated each section noting changes and adjustment to the Proposal. Upon review the MCO identified inconsistent data due to definitions incorrectly worded however, revalidation was completed, and inconsistencies have been updated and amended. One success is the use of screening tools for SDoH exhibiting 14 screenings completed, of those 14, eight (8) were member interactions occurred and four (4) were referred for MLTSS services and transportation concerns. One significant limitation of concern was identified as untimely or no notification of inpatient admission. The MCO is a secondary payor which may not receive timely notification of admissions and/or discharges. CM continues to work collaboratively with BH and UM teams to improve notice of admissions and discharges. The MCO should continue to review and adjust changes as they occur, documenting each at the time of the change. The MCO should address the above concerns with clarifications or adjustments for a well-developed PIP that is demonstrative of the intended impact on performance outcomes.

WCHP – HEDIS Audit Review Table MY 2021

Audit Review Table					
WellCare Health Plans of New Jersey, Inc. (Org ID: 10793, Sub ID: 11953, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2021; Date & Timestamp - 6/14/2022 2:42:54 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		88.32%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		83.7%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.32%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		68.86%	R	R	Reported
Childhood Immunization Status - IPV		80.78%	R	R	Reported
Childhood Immunization Status - MMR		83.45%	R	R	Reported
Childhood Immunization Status - HiB		80.78%	R	R	Reported
Childhood Immunization Status - Hepatitis B		76.64%	R	R	Reported
Childhood Immunization Status - VZV		83.21%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		63.26%	R	R	Reported
Childhood Immunization Status - Hepatitis A		76.4%	R	R	Reported
Childhood Immunization Status - Rotavirus		57.91%	R	R	Reported
Childhood Immunization Status - Influenza		51.82%	R	R	Reported
Childhood Immunization Status - Combo 3		54.5%	R	R	Reported
Childhood Immunization Status - Combo 7		42.34%	R	R	Reported
Childhood Immunization Status - Combo 10		32.6%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		81.27%	R	R	Reported
Immunizations for Adolescents - Tdap		86.62%	R	R	Reported
Immunizations for Adolescents - HPV		31.39%	R	R	Reported
Immunizations for Adolescents - Combination 1		78.59%	R	R	Reported
Immunizations for Adolescents - Combination 2		29.2%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		70.8%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		57.88%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		53.04%	R	R	Reported

Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		67.4%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		54.29%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		31.34%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		69.42%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		92.05%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		52.95%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		64.48%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		70.45%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		83.1%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		73.77%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		0.48%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		1.45%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		0.97%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.48%	R	R	Reported
Comprehensive Diabetes Care (CDC)					
Comprehensive Diabetes Care - HbA1c Testing		87.35%	R	R	Reported
Comprehensive Diabetes Care - Poor HbA1c Control		36.01%	R	R	Reported
Comprehensive Diabetes Care - HbA1c Control (<8%)		54.01%	R	R	Reported
Comprehensive Diabetes Care - Eye Exams		56.69%	R	R	Reported
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)		61.8%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		35.66%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		75.08%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		68.01%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Antidepressant Medication Management - Effective Acute Phase Treatment		62.9%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		45.02%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		39.72%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		27.78%	NA	R	Reported
Follow-up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		38.2%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		23.37%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		68.43%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		57.83%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		45.78%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		25.3%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	Y				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 days (Total)		17.48%	R	R	Reported
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 days (Total)		12.24%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		24.24%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		80.2%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		78.93%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		90%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		71.57%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				

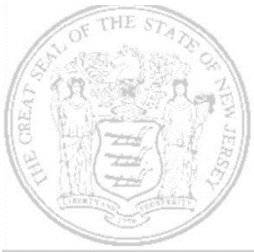
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		49.55%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		40.54%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		39.64%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.37%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		84.19%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		56.3%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain		77.81%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		6.48%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		9.47%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.03%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.36%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		11.12%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		5.09%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		77.94%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (Total)		51.99%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Y				
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Alcohol Abuse or Dependence (Total)		40%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Alcohol Abuse or Dependence (Total)		3.83%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Opioid Abuse or Dependence (Total)		41.61%	R	R	Reported

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Opioid Abuse or Dependence (Total)		13.66%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Other Drug Abuse or Dependence (Total)		44.32%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Other Drug Abuse or Dependence (Total)		4.55%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Initiation of AOD - Total (Total)		40.4%	R	R	Reported
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment - Engagement of AOD - Total (Total)		7.12%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		83.21%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		75.43%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		62.5%	NA	R	Reported
Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		44.41%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		73.09%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		62.7%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMBa)			R	R	Reported
Ambulatory Care (Dual) (AMBb)			R	R	Reported
Ambulatory Care (Disabled) (AMBc)			R	R	Reported
Ambulatory Care (Low Income) (AMBd)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPUa)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Dual) (IPUb)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Disabled) (IPUc)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (Low Income) (IPUd)			R	R	Reported
Identification of Alcohol and other Drug Services (IADa)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Dual) (IADb)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Disabled) (IADc)	Y		R	R	Reported
Identification of Alcohol and Other Drug Services (Low Income) (IADd)	Y		R	R	Reported

Mental Health Utilization (MPTa)	Y		R	R	Reported
Mental Health Utilization (Dual) (MPTb)	Y		R	R	Reported
Mental Health Utilization (Disabled) (MPTc)	Y		R	R	Reported
Mental Health Utilization (Low Income) (MPTd)	Y		R	R	Reported
Antibiotic Utilization (ABXa)	Y		R	R	Reported
Antibiotic Utilization (Dual) (ABXb)	Y		R	R	Reported
Antibiotic Utilization (Disabled) (ABXc)	Y		R	R	Reported
Antibiotic Utilization (Low Income) (ABXd)	Y		R	R	Reported
Risk Adjusted Utilization					
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENPa)			R	R	Reported
Enrollment by Product Line (Dual) (ENPb)			R	R	Reported
Enrollment by Product Line (Disabled) (ENPc)			R	R	Reported
Enrollment by Product Line (Low Income) (ENPd)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Electronic Clinical Data Systems					
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		57.76%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		39.72%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		27.78%	NA	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period1 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period2 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Period3 (Total)		0%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-up PHQ-9 (Total)			NA	R	Reported

Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza		13.87%	R	R	Reported
Adult Immunization Status - Td/Tdap		16.99%	R	R	Reported
Adult Immunization Status - Zoster		1.6%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		18.01%	R	R	Reported
Prenatal Immunization Status - Tdap		31.71%	R	R	Reported
Prenatal Immunization Status - Combination		9.83%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

Appendix B: ABHNJ 2022 Core Medicaid and MLTSS Care Management Audits



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Aetna Better Health New Jersey
Review Period: January 1, 2021 – December 31, 2021

November 2022

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction 4

Methodology 4

Pre-Audit Activities 4

Audit Activities 6

Audit Results 6

GP Population Findings 6

DDD Population Findings 10

DCP&P Population Findings 12

Conclusions 15

Care Management Annual Assessment 16

Care Management 16

List of Tables

Table 1: Sampling Methodology 5
Table 2: Aggregate Results by Category 6
Table 3: Identification – GP Population 6
Table 4: Outreach – GP Population 7
Table 5: Preventive Services – GP Population 8
Table 6: Continuity of Care – GP Population 8
Table 7: Coordination of Services – GP Population 9
Table 8: Outreach – DDD Population 10
Table 9: Preventive Service – DDD Population 10
Table 10: Continuity of Care – DDD Population 11
Table 11: Coordination of Services – DDD Population 12
Table 12: Outreach – DCP&P Population 12
Table 13: Preventive Services – DCP&P Population 13
Table 14: Continuity of Care – DCP&P Population 14
Table 15: Coordination of Services – DCP&P Population 14
Table 16: Rating Scale for the Annual Care Management Assessment 16
Table 17: Summary of Findings for Care Management Annual Assessment 17
Table 18: Findings for Deficient Care Management Elements 18

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 192 cases for Aetna Better Health of New Jersey (ABHNJ), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (54). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (28).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599, 49499 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2021	>= 3 months as of 12/31/2021	>= 3 months and < 18 years as of 12/31/2021
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2021 to 7/1/2021	Initial enrollment between 1/1/2021 and 12/31/2021	Initial enrollment between 1/1/2021 and 12/31/2021
Current Enrollment	Enrolled as of 12/31/2021	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2021 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's 2021 audit results ranged from 38% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP 2021 (n=100)	GP 2020 (n=100)	PPD[2]	DDD 2021 (n=28)	DDD 2020 (n=54)	PPD[2]	DCP&P 2021 (n=37)	DCP&P 2020 (n=84)	PPD[2]
Identification[1]	68%	84%	-16-						
Outreach	63%	91%	-27	98%	100%	-2	100%	98%	2
Preventive Services	38%	86%	-48	66%	42%	23	71%	56%	15
Continuity of Care	59%	69%	-10	91%	80%	11	93%	92%	1
Coordination of Services	73%	81%	-8	98%	74%	24	99%	87%	12

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

[2]Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 7 Enrollees were new Enrollees, and 93 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	2	0.0%	100.0%	-100.0
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's	1	3	33.3%	0.0%	33.3

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
enrollment (applies to new Enrollees only)					
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) *	3	4	75.0%	40.7%	34.3
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	1	1	0.0%[2]	100.0%[2]	-100.0
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020) *	20	94	21.3%	23.3%	-2.0
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020)	21	74	71.6%[2]	89.3%[2]	-17.7
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management) *	23	52	44.2%	50.0%	-5.8

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] Percentage rate is indicative of an inverse percentage.

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (56).

Table 4: Outreach – GP Population

Outreach	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	26	56	46.4%	89.7%	-43.3
The outreach for CNA was timely within 30 days of the identification of CM needs	26	26	100.0%	91.4%	8.6
Outreach was successful (even if the Enrollee declines to complete the CNA) *	14	26	53.8%	68.6%	-14.7
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	7	9	77.8%	90.0%	-12.2
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	6	14	42.9%	41.7%	1.2
The Enrollee declined Care Management*	6	26	23.1%	37.1%	-14.1

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (94).

Table 5: Preventive Services – GP Population

Preventive Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	10	12	83.3%	66.7%	16.7
Aggressive outreach attempts were documented to confirm EPSDT status	0	2	0.0%	100.0%	-100.0
The Care Manager sent EPSDT reminders	0	2	0.0%	0.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	6	9	66.7%	66.7%	0.0
Aggressive outreach attempts were documented to confirm immunization status	2	3	66.7%	100.0%	-33.3
Appropriate vaccines have been administered for Enrollees aged 18 and above	22	85	25.9%	88.9%	-63.0
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	14	63	22.2%	100.0%	-77.8
Dental needs are addressed for Enrollees aged 21 and above	38	82	46.3%	100.0%	-53.7
A dental visit occurred during the review period for Enrollees aged 1 to 21	5	12	41.7%	50.0%	-8.3
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	4	7	57.1%	100.0%	-42.9
Dental reminders were sent to Enrollees aged 1 to 21	4	7	57.1%	100.0%	-42.9
Enrollees aged 9 months to 26 months were tested twice for lead	1	7	14.3%	0.0%	14.3
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	4	25.0%	0.0%	25.0
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	3	3	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	6	6	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

This section includes Enrollees with identified Care Management needs who accept Care Management, or who were already in Care Management (65). If members decline Care Management afterwards, they will be removed from this section.

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
A Comprehensive Needs Assessment was completed for the Enrollee	12	65	18.5%	40.0%	-21.5
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)[2]	8	12	66.7%	72.7%	-6.1

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
A level of Care Management was determined for the Enrollee	12	12	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	10	94	10.6%	23.3%	-12.7
A Care Plan was completed for the Enrollee that included all required components	19	19	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	12	12	100.0%	42.3%	57.7
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	17	18	94.4%	100.0%	-5.6
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	6	6	100.0%	CNC[3]	CNC[3]

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Could not calculate

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (94).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	48	94	51.1%	36.7%	14.4
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	34	34	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider	32	32	100.0%	100.0%	0.0

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
services, utilization management) as appropriate for the Enrollee					
For Enrollees who were hospitalized, adequate discharge planning was performed	26	33	78.8%	100.0%	-21.2

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DDD Population Findings

A total of 28 files were reviewed for the DDD Population with no exclusion.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	27	28	96.4%	100.0%	-3.6
The outreach for CNA was timely within 45 days of enrollment	27	27	100.0%	100.0%	0.0
Outreach was successful (even if the Enrollee declines to complete the CNA) *	21	27	77.8%	77.8%	0.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	22	22	100.0%	97.8%	2.2
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	4	22	18.2%	23.8%	-5.6
The Enrollee declined Care Management*	4	27	14.8%	18.5%	-3.7

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	8	13	61.5%	36.4%	25.2
Aggressive outreach attempts were documented to confirm EPSDT status	5	5	100.0%	76.2%	23.8
The Care Manager sent EPSDT reminders	5	5	100.0%	9.5%	90.5
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	4	11	36.4%	13.6%	22.7
Aggressive outreach attempts were documented to confirm immunization status	6	11	54.5%	57.9%	-3.3
Appropriate vaccines have been administered for Enrollees aged 18 and above	6	17	35.3%	46.9%	-11.6
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	7	11	63.6%	64.7%	-1.1
Dental needs are addressed for Enrollees aged 21 and above	26	28	92.9%	66.7%	26.2
A dental visit occurred during the review period for Enrollees aged 1 to 21	3	12	25.0%	15.2%	9.8
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	8	9	88.9%	60.7%	28.2
Dental reminders were sent to Enrollees aged 1 to 21	8	9	88.9%	35.7%	53.2

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Enrollees aged 9 months to 26 months were tested twice for lead	0	0	CNC[2]	0.0%	CNC[2]
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	0	CNC[2]	0.0%	CNC[2]
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	0	0	CNC[2]	100.0%	CNC[2]
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	0	0	CNC[2]	100.0%	CNC[2]

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] Could not calculate

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	17	24	70.8%	51.9%	19.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	17	24	70.8%	78.6%	-7.7
A level of Care Management was determined for the Enrollee	17	17	100.0%	96.4%	3.6
The Enrollee is in Community Based Care Management (CBCM)*	6	24	25.0%	11.1%	13.9
A Care Plan was completed for the Enrollee that included all required components	17	17	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	17	17	100.0%	51.9%	48.1
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[3]	100.0%	CNC[3]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[3]	CNC[3]	CNC[3]

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Could not calculate

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	23	24	95.8%	55.6%	40.3
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	18	18	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	18	18	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%	66.7%	33.3
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2021 the Care Manager documented evidence of follow up within 30 days of discharge	1	1	100.0%	CNC[2]	CNC[2]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[2]	CNC[2]	CNC[2]

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] Could not calculate

DCP&P Population Findings

A total of 54 files were reviewed for the DCP&P Population. (17) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	37	37	100.0%	97.6%	2.4
The outreach for CNA was timely within 45 days of enrollment	37	37	100.0%	98.8%	1.2
Outreach was successful (even if the Enrollee declines to complete the CNA) *	30	37	81.1%	84.1%	-3.1
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	31	31	100.0%	100.0%	0.0
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	31	0.0%	24.6%	-24.6

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

**Not Included in aggregate score calculation*

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	31	37	83.8%	70.2%	13.5
Aggressive outreach attempts were documented to confirm EPSDT status	6	6	100.0%	84.0%	16.0
The Care Manager sent EPSDT reminders	3	6	50.0%	20.0%	30.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	21	37	56.8%	51.2%	5.6
Aggressive outreach attempts were documented to confirm immunization status	34	37	91.9%	65.9%	26.0
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	0	CNC[2]	CNC[2]	CNC[2]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	0	0	CNC[2]	CNC[2]	CNC[2]
Dental needs are addressed for Enrollees aged 21 and above	33	37	89.2%	CNC[2]	CNC[2]
A dental visit occurred during the review period for Enrollees aged 1 to 21	12	32	37.5%	53.1%	-15.6
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	14	20	70.0%	70.0%	0.0
Dental reminders were sent to Enrollees aged 1 to 21	17	20	85.0%	26.7%	58.3
Enrollees aged 9 months to 26 months were tested twice for lead	0	10	0.0%	0.0%	0.0
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	2	10	20.0%	5.6%	14.4
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	10	10	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	10	10	100.0%	94.4%	5.6

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] Could not calculate.

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	30	37	81.1%	69.0%	12.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	30	37	81.1%	74.1%	6.9
A level of Care Management was determined for the Enrollee	30	30	100.0%	98.3%	1.7
A Care Plan was completed for the Enrollee that included all required components	28	28	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	28	30	93.3%	96.4%	-3.1
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[3]	100.0%	CNC[3]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[3]	CNC[3]	CNC[3]

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Could not calculate.

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	37	37	100.0%	81.0%	19.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	32	33	97.0%	100.0%	-3.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	32	32	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	0	0	CNC[2]	75.0%	CNC[2]

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] Could not calculate.

Limitations

Audit results for the DDD and DCP&P Population should be considered cautiously due to the low sample size of 28 and 54 respectively.

Conclusions

Overall, ABHNJ scored 85% and above in the following review categories (**Table 2**):

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

Overall, ABHNJ scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (68%)
- Outreach (General Population) (63%)
- Preventive Services (General Population) (38%)
- Continuity of Care (General Population) (59%)
- Coordination of Services (General Population) (73%)
- Preventive Services (DDD Population) (66%)
- Continuity of Care (DDD Population) (84%)
- Preventive Services (DCP&P Population) (71%)

Care Management

Assessment Methodology

The Care Management Annual Assessment review consisted of pre-audit review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key ABHNJ staff via WebEx were held on May 23, 2022, and post-audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on February 10, 2022 and received documentation from the MCOs on February 25, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on February 28, 2022. The audit review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2021, to December 31, 2021.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met in Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions. ABHNJ received an overall compliance score of 80% in 2022. In 2021, the MCO received a score of 83%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM13, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2022. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s).

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	-	X	-	X	-	X	-	-
CM3	X	X	-	X	-	-	-	X
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	X	X	-	X	-	-	-	X
CM7	-	X	-	X	-	X	-	-
CM8	-	X	X	-	-	-	X	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	X	X	X	-	-	-	-	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	-	X	-	X	-	X	-	-
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
TOTAL	25	30	24	7	0	4	1	2
Compliance Percentage			80%					

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 78.8% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees: Identification:** 71.6% - Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) 44.2% - Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (CAN) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 0.0% - CNA was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only). 33.3% - When the initial outreach for the CNA was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only).

Element	Contract Language	Reviewer Comments
	Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved CAN tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CAN)** The MCO will conduct an approved CAN on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 CM file audit the Plan scored for the General Population Enrollees: Outreach:** 18.5%-A Comprehensive Needs Assessment was completed for the Enrollee 66.7%- Initial outreach to complete a CNA was done. 77.8% - When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment. **In the 2022 CM file audit the Plan scored for the DDD Enrollees:** 70.8% - Comprehensive Needs Assessment (CNA) was done and includes all required elements. 70.8% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). **In the 2022 CM file audit the Plan scored for the DCP&P Enrollees**: 81.1% - Comprehensive Needs Assessment (CNA) was done and includes all required elements. 81.1% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees: Preventive Services:** 83.3% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.

Element	Contract Language	Reviewer Comments
		0.0% - Aggressive outreach attempts were documented to confirm EPSDT status. 0.0% - The Care Manager sent EPSDT reminders. 66.7% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 66.7% - Aggressive outreach attempts were documented to confirm immunization status. 25.9% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 22.2% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above. 46.3% - Dental needs are addressed for Enrollees aged 21 and above. 41.7% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 57.1% - Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21. 57.1% - Dental reminders were sent to Enrollees aged 1 to 21. 14.3% - Enrollees aged 9 months to 26 months were tested twice for lead. 25.0% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. **In the 2022 CM file audit the Plan scored for the DDD Population Enrollees:** 61.5% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.

Element	Contract Language	Reviewer Comments
		36.4% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 54.5% - Aggressive outreach attempts were documented to confirm immunization status. 35.3% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 63.6% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above. 25.0% - A dental visit occurred during the review period for Enrollees aged 1 to 21. **In the 2022 CM file audit the Plan scored for the DCP&P Population Enrollees:** 83.8% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 50.0% - The Care manager sent EPSDT reminders. 56.8% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 37.5% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 70.0% - Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 20.0% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

Element	Contract Language	Reviewer Comments
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees: Coordination of Services:** 51.1% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

Table 19: Resolved Deficiency for Care Management Element

Element	Contract Language
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf

Recommendations

For The General Population:

1. **CM2:** ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed.
2. **CM3:** ABHNJ should ensure that appropriate Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a Care Manager.
3. **CM3:** ABHNJ should ensure that appropriate Enrollees are identified by the MCO as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management).
4. **CM6:** ABHNJ should ensure that the IHS is completed within 45 days of enrollment (applies to new Enrollees only) and should ensure that when the initial outreach for the IHS is unsuccessful, aggressive outreach attempts are documented and are done within 45 days of the Enrollees enrollment (applies to new enrollees only).
5. **CM7:** ABHNJ should ensure that the initial outreach to complete the CNA is done and a CNA is completed for the enrollee.
6. **CM7:** ABHNJ should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and were done within 45 days of the Enrollee's enrollment.
7. **CM14**: ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and

status is confirmed by a reliable source and should ensure that aggressive outreach attempts are documented to confirm EPSDT status, and the Care Manager sends EPSDT reminders.

8. **CM14**: ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source
9. **CM14**: ABHNJ should ensure that appropriate vaccines are administered for Enrollees aged 18 and above and should ensure that aggressive outreach attempts are documented to confirm immunization status for Enrollees aged 18 and above.
10. **CM14:** ABHNJ should ensure that dental needs are addressed for Enrollees aged 21 and above and should ensure a dental visit occurred during the review period.
11. **CM14**: ABHNJ should ensure that the Care Manager makes attempts to obtain dental status for Enrollees aged 1 21 and those Dental reminders are sent to Enrollees aged 1 to 21.
12. **CM14**: ABHNJ should ensure that Enrollees aged 9 months to 26 months are tested twice for lead and should ensure that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.
13. **CM19:** ABHNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

For The DDD Population

1. **CM7:** ABHNJ should ensure that Comprehensive Needs Assessment (CNA) is done and includes all required elements and should ensure that the CNA is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM14:** ABHNJ should ensure that The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source**.**
3. **CM14:** ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
4. **CM14**: ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees aged 18 and above and should ensure that aggressive outreach attempts were documented to confirm immunization status age 18 and above.
5. **CM14:** ABHNJ should ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21.

For The DCP&P Population

1. **CM7**: ABHNJ Comprehensive Needs Assessment (CNA) is done and includes all required elements and the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM14**: ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source and should ensure that the Care Manager sends EPSDT reminders.
3. **CM14**: ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
4. **CM14** ABHNJ should ensure a dental visit occurred during the review period for Enrollees aged 1 to 21 and should ensure that the Care Manager make attempts to obtain dental status for Enrollees aged 1 to 21.
5. **CM14:** ABHNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
6. **CM14:** ABHNJ should ensure that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Aetna Better Health New Jersey

Review Period August 15, 2021 – June 30, 2022

April 2023

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2021 and January 2022. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 110 cases for Aetna Better Health New Jersey (ABHNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 10/26/2021. A sample of 50 high-risk cases with an oversample of four cases was drawn for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 110 cases selected for the MCO, 103 Member files were reviewed and 100 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	26
Group D	Current Members Newly Enrolled to MLTSS	25
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	52
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	3

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 40.5% to 94.7% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	August 2021 – June 2022			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		40.5%		40.5%
Member Outreach	92.0%	56.0%		74.0%
Telephonic Monitoring or Face-to-Face Visits	69.1%	74.1%	70.1%	70.9%
Initial Plan of Care (Including Back-up Plans)	88.3%	84.0%	94.8%	90.7%
Ongoing Care Management	64.9%	58.7%	53.8%	58.1%
Gaps in Care/Critical Incidents	96.1%	92.2%	95.2%	94.7%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 26 files were reviewed for new Members enrolled in managed care and newly eligible for MLTSS (Group C) and 1 file was excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 25 files were further reviewed for compliance in five (5) categories.

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	23	25	92.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	3	25	12.0%
Member was offered the participant direction option.[1]	15	18	83.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	3	4	75.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	21	25	84.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	21	25	84.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	9	18	50.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	24	24	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	16	24	66.7%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	17	18	94.4%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	17	17	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	18	18	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	17	18	94.4%
Member file included a Member Rights and Responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	23	25	92.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	17	18	94.4%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	2	50.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	6	25	24.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	22	25	88.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	3	3	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	8	17	47.1%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	1	1	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	3	4	75.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	2	2	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	1	0.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	24	25	96.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 25 files were further reviewed for compliance in all six (6) categories.

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	17	25	68.0%
Screening for Community Services Assessment was submitted to DoAS by the 10th of the following month.	0	17	0.0%

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	14	25	56.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	3	25	12.0%
Member was offered the participant direction option.[1]	20	21	95.2%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	9	12	75.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	23	25	92.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	14	25	56.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	14	21	66.7%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	6	6	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	22	23	95.7%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	21	23	91.3%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	17	21	81.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	17	17	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	20	21	95.2%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	15	18	83.3%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these Rights and Responsibilities had been explained to the Member, and that the Member understood them.	18	25	72.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	20	21	95.2%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	1	0.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	2	25	8.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	22	25	88.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	3	0.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	8	17	47.1%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	1	1	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	3	6	50.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	5	5	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	23	25	92.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	23	25	92.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 52 files were reviewed for the Members enrolled in managed care and MLTSS prior to the review period (Group E) and 2 files were excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Outreach is not assessed for Members in Group E. All 37 files were reviewed for compliance in four (4) categories.

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	49	50	98.0%
Options Counseling was provided to the Member.	6	50	12.0%
Member was offered the participant direction option.	45	50	90.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	6	10	60.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	41	50	82.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	1	100.0%

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the Member's anniversary (from the date of the Initial Plan of Care).	N/A[1]	N/A[1]	N/A[1]
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	48	50	96.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	49	50	98.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	6	8	75.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1-Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.	49	49	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	46	49	93.9%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	47	50	94.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	46	47	97.9%
Care Manager completed an Annual Risk Assessment for the Member (not applicable for Members residing in CARS).	47	50	94.0%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.[2]	50	50	100.0%

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	43	46	93.5%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	42	50	84.0%

[1]Due to the nature of the audit and the timeframe, this was not included in the current audit

[2] The numerator represents the Members that were identified by IPRO as having a potential risk that the Care Manager also identified

	August 2021 - June 2022		
Ongoing Care Management	N	D	Rate
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	2	8	25.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	9	50	18.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	49	50	98.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	1	0.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	21	47	44.7%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	5	5	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	2	6	33.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	4	4	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	50	98.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	1	4	25.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	49	50	98.0%

4. Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #9a (Member's Plan of Care is amended based on change of Member condition), #10 (Plans of Care are aligned

with Members needs based on the results of the NJ Choice Assessment), #11 (Plans of Care developed using "Person-Centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2021-2022 audit findings. Overall, the MCO's audit results ranged from 85.4% to 100% across all groups for five (5) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures: ABHNJ

Performance Measure	Group[1]	August 2021 - June 2022		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C			
	Group D			
	Group E			
	Ancillary Group C			
	Ancillary Group D			
	Total			
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E			
	Total			
#9a. Member's Plan of Care is amended based on change of Member condition[4]	Group C	2	2	100.0%
	Group D	5	5	100.0%
	Group E	4	4	100.0%
	Total	11	11	100.0%
#10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment[5]	Group C	16	21	76.2%
	Group D	19	20	95.0%
	Group E			
	Total	35	41	85.4%
#11. Plans of Care developed using "Person-Centered principles"[6]	Group C	16	24	66.7%
	Group D	21	23	91.3%
	Group E	46	49	93.9%
	Total	83	96	86.5%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	17	18	94.4%
	Group D	17	21	81.0%
	Group E	47	50	94.0%
	Total	81	89	91.0%
#16. Member training on identifying/reporting critical incidents	Group C	24	25	96.0%
	Group D	23	25	92.0%
	Group E	49	50	98.0%
	Total	96	100	96.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period

[2]This measure was not calculated during this review

[3]This measure was not calculated during this review

[4]Members who did not have a documented change in condition during the study period are excluded from this measure

[5]Group E members are excluded from this measure

[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC

[7]Members in CARS are excluded from this measure

N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 40.5% in the Assessment category.

Group	8/21 to 6/22
Group C	
Group D	40.5%
Group E	
Combined	40.5%

Opportunities for Improvement for the elements of *Assessment* category include the following:

- Group D: Aetna should ensure that a Screening Community Service Assessment (SCS) is utilized to identify potential MLTSS needs and is submitted to DoAS by the 10th of the month following completion of the SCS.

Member Outreach

Across groups, the MCO had a combined score of 74.0% in the Member Outreach category.

Group	8/21 to 6/22
Group C	92.0%
Group D	56.0%
Group E[1]	
Combined	74.0%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for the elements of *Member Outreach* category include the following:

- Group D: Aetna should ensure that the Care Manager contacts the Member telephonically to conduct a Screening for Community Services assessment and completes the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring or Face-to-Face Visits

Across all three groups, the MCO had a combined score of 70.9% in the Telephonic Monitoring or Face-to-Face Visits category.

Group	8/21 to 6/22
Group C	69.1%
Group D	74.1%
Group E	70.1%
Combined	70.9%

Opportunities for Improvement for elements of the *Telephonic Monitoring or Face-to-Face Visits* category include the following:

- Group C: Aetna should ensure that Options Counseling was provided to the Member and if participant direction was selected, the application package is submitted within thirty (30) business days of completion. Aetna should ensure Members have a cost neutrality analysis on file during the review period and includes a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.

- Group D: Aetna should ensure that Options Counseling was provided to the Member and if participant direction was selected, the application package is submitted within thirty (30) business days of completion.

- Group E: Aetna should ensure that Options Counseling was provided to the Member and if participant direction is selected, the application packages are submitted within thirty (30) business days of completion. Aetna should ensure Members have a cost neutrality analysis on file during the review period and includes a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.

Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 90.7% in the Initial Plan of Care (Including Back-up Plans) category.

Group	8/21 to 6/22
Group C	88.3%
Group D	84.0%
Group E	94.8%
Combined	90.7%

Opportunities for Improvement for elements at the group level of the *Initial Plan of Care (Including Back-up Plans) category with a score below 86%* include the following*:*

- Group D: Aetna should ensure that the Member has a completed signed or verbally acknowledged Plan of Care that is provided to the Member and/or Member representative within 45 days of enrollment into the MLTSS program. Aetna should ensure that the Member was assessed for PCA services within 45 days of enrollment into MLTSS. Aetna should ensure for those Members requiring a Back-up Plan, that the Back-up Plan is signed/verbally acknowledged (not applicable for Members residing in CARS). Aetna should ensure that Members identified as having a potential risk have a signed/verbally acknowledged Risk Management

Agreement with all of its components (not applicable for Members residing in CARS). Aetna should ensure the Member file contains a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member has received his/her rights and responsibilities in writing, that these rights and responsibilities have been explained to the Member, and that the Member understands them.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 58.1% in the Ongoing Care Management category.

Group	8/21 to 6/22
Group C	64.9%
Group D	58.7%
Group E	53.8%
Combined	58.1%

Opportunities for Improvement for elements of the *Ongoing Care Management* category include the following:

- Group C: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members who were enrolled long enough for a quarterly update and have services that required a Back-up Plan, have the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure for Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge.

- Group D: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge.

- Group E: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 94.7% in the Gaps in Care/Critical Incidents category.

Group	8/21 to 6/22
Group C	96.1%
Group D	92.2%
Group E	95.2%
Combined	94.7%

Performance Measures

Overall, The MCO scored below 86% in one (1) of the five (5) performance measures.

- PM #10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment

Opportunities for Improvement at the group level for Performance Measures *for scores less than 86%* include the following:

- Group C: PM #10: Aetna should ensure the Member's Plan of Care aligns with the needs identified on the NJ Choice Assessment and the Plan of Care is signed or verbally acknowledged by the Member and/or authorized representative.

- Group C: PM #11: Aetna should ensure the Member's Plan of Care developed using "Person-Centered principles" is signed or verbally acknowledged by the Member and/or authorized representative.

- Group D: PM #12: Aetna should ensure that the MLTSS Home and Community-Based Services (HCBS) Plans of Care contain a Back-up Plan that is signed or verbally acknowledged by the Member and/or authorized representative.

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

Aetna Better Health of New Jersey
Managed Long Term Services and Supports (MLTSS)
2022 Annual Assessment Review of
Care Management

Review Period - July 1, 2021 to June 30, 2022

January 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction……4

Care Management and Continuity of Care……6

List of Tables

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management……5

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care……6

Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standards under review; interviews with key ABHNJ staff (held via WebEx on January 12, 2023) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on October 21, 2022 and received from the MCOs on November 4, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on November 7, 2022. The offsite review team was made up of Carla Zuccarello, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2021 to June 30, 2022. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2022 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be submitted once completed.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. ABHNJ received an overall compliance score of 100% in 2022. In 2021, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage			**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Aetna Better Health New Jersey

February 2023

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30th. Due to COVID-19, the prior review period was from July 1, 2019 through February 29th, 2020. An extension period was included through March 1, 2020 through December 31st, 2020 to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was Janaury 1, 2021 through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 through August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020 where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF/SCNF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Aetna Better Health New Jersey (ABHNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on August 14, 2021, and
- The member must have been enrolled as a NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on August 14, 2021, and
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (August 14, 2021).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF at least six (6) consecutive months between January 1, 2021 and August 14, 2021 with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months, and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for ABHNJ, 100 member files were reviewed and included in the results pertaining to the Plan of Care for Institutional Settings. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" (not applicable) were not included in scoring. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting (see **Tables 2a-e**)**.** Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold both in the tables and Conclusion section of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	70	100	70.0%
Documented Review of the Facility Plan of Care by the Care Manager	68	70	97.1%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	69	70	98.6%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (January 1, 2021-August 14, 2021)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature**) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS)	3	4	75.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	89	100	89.0%
Care Manager arranged Plan of Care services using both formal and informal supports	93	100	93.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	89	100	89.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2-measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	94	100	94.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	89	100	89.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	1	0.0%

Table 2c.

Transition Planning	Review Period (January 1, 2021-August 14, 2021)		
	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	89	100	89.0%
Evidence of the **Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	14	100	14.0%
Member was present at each telephonic visit or was involved from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in a telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	92	100	92.0%
Timely telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	36	100	36.0%
Members requiring coordination of care had coordination of care by the Care Manager	96	100	96.0%
Care Manager explained and discussed any payment liability with the Member if a member had any payment liability for the NF/SCNF admission	57	100	57.0%

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	89	100	89.0%
Care Manager reviewed the Member's Rights and Responsibilities	89	100	89.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	89	100	89.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	89	100	89.0%

CNC: Could not calculate

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period	N/A		
Member was admitted to an NF/SCNF during the review period	N/A		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	N/A	N/A	N/A

N/A: Not Applicable (PASRR questions were removed this year; Due to the COVID-19 pandemic, face-to-face visits were placed on hold)

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for ABHNJ, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

NF/SCNF Members Transitioned to HCBS	Review Period (January 1, 2021- August 14, 2021)		
	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC

CNC: Could not calculate

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF/SCNF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: ABHNJ

Performance Measure	Group	January 2021 – August 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	3	4	75.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	3	4	75.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	89	100	89.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	89	100	89.0%
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	1	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	1	0.0%
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	89	100	89.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	89	100	89.0%
#16. Member training on identifying/reporting critical incidents	Group 1	89	100	89.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	89	100	89.0%

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

Limitations

The annual NF/SCNF CM Audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. During the 2021 NF/SCNF CM Audit the MCOs were only evaluated based on scores from the review period (period through which they could conduct normal business activities) not the expansion period. The 2021 NF CM review period changed from a full year review to a partial year review beginning January 1, 2021 and ending August 14, 2021.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (97.1%)
- MLTSS Plan of Care on file (98.6%)
- Care Managers used a person-centered approach (89.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (93.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (89.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (94.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (89.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (89.0%)
- Member was present at each telephonic visit (92.0%)
- Members requiring coordination of care had coordination of care (96.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (89.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (89.0%)
- Member and/or representative had training on how to report a critical incident (89.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (70.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for members newly enrolled in MLTSS.) (75.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (14.0%)
- Timely Telephonic Review of Member Placement and Services (36.0%)
- Care Manager explained and discussed any payment liability (57.0%)

Recommendations for audit elements include the following:

Aetna's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The Care Manager should ensure that Member's Plan

of Care is reviewed, revised if applicable for any significant changes, and confirm the agreement/disagreement statement is reviewed and signed by the Member/POA. The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. Aetna should ensure timely telephonic review of member placement and services and the MLTSS Care Managers should discuss payment liability and review the Member's placement and services timely.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (75.0%)
- #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

Recommendations for MLTSS Performance Measures include the following:

Aetna's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix C: AGNJ 2022 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Amerigroup New Jersey
Review Period: January 1, 2021 – December 31, 2021

November 2022

Table of Contents

Introduction 4

Methodology 4

Pre-Audit Activities 4
Audit Activities 6

Audit Results 6

GP Population Findings 6
DDD Population Findings 11
DCP&P Population Findings 13
Conclusions 16

Care Management Annual Assessment 17

Care Management 17
Recommendations: 23

List of Tables

Table 1: Sampling Methodology 5
Table 2: Aggregate Results by Category 6
Table 3: Identification – GP Population 6
Table 4: Outreach – GP Population 8
Table 5: Preventive Services – GP Population 8
Table 6: Continuity of Care – GP Population 9
Table 7: Coordination of Services – GP Population 10
Table 8: Outreach – DDD Population 11
Table 9: Preventive Service – DDD Population 11
Table 10: Continuity of Care – DDD Population 12
Table 11: Coordination of Services – DDD Population 12
Table 12: Outreach – DCP&P Population 13
Table 13: Preventive Services – DCP&P Population 13
Table 14: Continuity of Care – DCP&P Population 14
Table 15: Coordination of Services – DCP&P Population 15
Table 16: Rating Scale for the Annual Care Management Assessment 17
Table 17: Summary of Findings for Care Management Annual Assessment 18
Table 18: Findings for Deficient Care Management Elements 19
Table 19: Findings for Resolved Deficiencies for Care Management Elements 23

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 201 cases for Amerigroup New Jersey, Inc. (AGNJ) including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (68). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (22).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599, 49499 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2021	>= 3 months as of 12/31/2021	>= 3 months and < 18 years as of 12/31/2021
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2021 to 7/1/2021	Initial enrollment between 1/1/2021 and 12/31/2021	Initial enrollment between 1/1/2021 and 12/31/2021
Current Enrollment	Enrolled as of 12/31/2021	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2021 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

AGNJ's 2021 audit results ranged from 29% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP 2021 (n=100)	GP 2020 (n=100)	PPD[2]	DDD 2021 (n=17)	DDD 2020 (n=39)	PPD[2]	DCP&P 2021 (n=35)	DCP&P 2020 (n=73)	PPD[2]
Identification[1]	60%	93%	-33						
Outreach	64%	100%	-36	100%	99%	1	100%	98%	2
Preventive Services	29%	60%	-32	76%	60%	16	81%	77%	4
Continuity of Care	47%	64%	-17	90%	91%	-1	99%	97%	2
Coordination of Services	41%	92%	-52	100%	96%	4	100%	100%	0

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

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

GP Population Findings

A total of 101 files were reviewed for the GP Population. Of the 101 files reviewed, 1 enrollee is excluded, 3 Enrollees were new Enrollees, and 97 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	1	0.0%	CNC[1]	CNC[1]
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's	2	2	100.0%	87.5%	12.5

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
enrollment (applies to new Enrollees only).					
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) *	3	3	100.0%	66.7%	33.3
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	0	CNC[1]	100.0%[2]	CNC[1]
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020) *	11	96	11.5%	11.0%	0.5
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020)	34	85	60.0%[2]	92.6%[2]	-32.6
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management) *	40	51	78.4%	71.6%	6.8

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] Percentage rate is indicative of an inverse percentage

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (79).

Table 4: Outreach – GP Population

Outreach	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	40	79	50.6%	100.0%	-49.4
The outreach for CNA was timely within 30 days of the identification of CM needs	36	40	90.0%	100.0%	-10.0
Outreach was successful (even if the Enrollee declines to complete the CNA) *	1	40	2.5%	39.1%	-36.6
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	22	23	95.7%	92.0%	3.7
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	2	50.0%	40.0%	10.0
The Enrollee declined Care Management*	10	40	25.0%	28.1%	-3.1

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (88).

Table 5: Preventive Services – GP Population

Preventive Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	15	22	68.2%	100.0%	-31.8
Aggressive outreach attempts were documented to confirm EPSDT status	2	7	28.6%	CNC[1]	CNC[1]
The Care Manager sent EPSDT reminders	2	7	28.6%	CNC[1]	CNC[1]
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	9	19	47.4%	0.0%	47.4
Aggressive outreach attempts were documented to confirm immunization status	0	10	0.0%	66.7%	-66.7
Appropriate vaccines have been administered for Enrollees aged 18 and above	14	69	20.3%	62.5%	-42.2
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	6	55	10.9%	33.3%	-22.4
Dental needs are addressed for Enrollees aged 21 and above	17	66	25.8%	68.8%	-43.0
A dental visit occurred during the review period for Enrollees aged 1 to 21	12	22	54.5%	100.0%	-45.5
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	3	11	27.3%	CNC[1]	CNC[1]
Dental reminders were sent to Enrollees aged 1 to 21	4	12	33.3%	CNC[1]	CNC[1]
Enrollees aged 9 months to 26 months were tested twice for lead	1	8	12.5%	33.3%	-20.8
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	2	3	66.7%	0.0%	66.7
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	1	1	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	4	7	57.1%	100.0%	-42.9

[1] Could not calculate

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

This section includes Enrollees with identified Care Management needs who accept Care Management, or who were already in Care Management (78). If members decline Care Management afterwards, they will be removed from this section.

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
A Comprehensive Needs Assessment was completed for the Enrollee	10	78	12.8%	31.6%	-18.8
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)[1]	8	10	80.0%	100.0%	-20.0%
A level of Care Management was determined for the Enrollee	10	10	100.0%	66.7%	33.3
The Enrollee is in Community Based Care Management (CBCM)*	14	88	15.9%	36.8%	-20.9
A Care Plan was completed for the Enrollee that included all required components	11	11	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	10	10	100.0%	83.3%	16.7
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	11	11	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	9	9	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (88).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	33	88	37.5%	73.7%	-36.2
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	23	53	43.4%	100.0%	-56.6
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	23	62	37.1%	100.0%	-62.9
For Enrollees who were hospitalized, adequate discharge planning was performed	20	41	48.8%	100.0%	-51.2

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DDD Population Findings

A total of 22 files were reviewed for the DDD Population with 5 exclusions.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	17	17	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	17	17	100.0%	97.4%	2.6
Outreach was successful (even if the Enrollee declines to complete the CNA) *	16	17	94.1%	92.3%	1.8
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	11	11	100.0%	100.0%	0.0
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	16	6.3%	5.6%	0.7
The Enrollee declined Care Management*	0	17	0.0%	5.1%	-5.1

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	10	11	90.9%	66.7%	24.2
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	1	1	100.0%	88.9%	11.1
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	3	9	33.3%	58.8%	-25.5
Aggressive outreach attempts were documented to confirm immunization status	9	9	100.0%	14.3%	85.7
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	8	0.0%	22.7%	-22.7
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	8	8	100.0%	58.8%	41.2
Dental needs are addressed for Enrollees aged 21 and above	17	17	100.0%	25.0%	75.0
A dental visit occurred during the review period for Enrollees aged 1 to 21	8	9	88.9%	48.1%	40.7
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	1	1	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees aged 1 to 21	1	1	100.0%	100.0%	0.0
Enrollees aged 9 months to 26 months were tested twice for lead	1	3	33.3%	0.0%	33.3
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	2	0.0%	100.0%	-100.0
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	2	2	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	2	2	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	16	17	94.1%	89.7%	4.4
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	16	22	72.7%	91.4%	-18.7
A level of Care Management was determined for the Enrollee	15	16	93.8%	100.0%	-6.3
The Enrollee is in Community Based Care Management (CBCM)*	0	17	0.0%	0.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	16	16	100.0%	91.7%	8.3
The Care Plan was developed within 30 days of CNA Completion	16	16	100.0%	86.1%	13.9
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	2	50.0%	33.3%	16.7
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100.0%	CNC[1]

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	17	17	100.0%	97.4%	2.6
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	16	16	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	16	16	100.0%	94.7%	5.3
For Enrollees who were hospitalized, adequate discharge planning was performed	4	4	100.0%	50.0%	50.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2021 the Care Manager documented evidence of follow up within 30 days of discharge	1	1	100.0%	100.0%	0.0
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	CNC[1]	CNC[1]

[1] Could not calculate

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DCP&P Population Findings

A total of 68 files were reviewed for the DCP&P Population. (33) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	35	35	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	35	35	100.0%	95.9%	4.1
Outreach was successful (even if the Enrollee declines to complete the CNA) *	34	35	97.1%	98.6%	-1.5
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	30	30	100.0%	95.2%	4.8
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	34	2.9%	6.9%	-4.0

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	29	35	82.9%	89.0%	-6.2
Aggressive outreach attempts were documented to confirm EPSDT status	6	6	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	6	6	100.0%	100.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	24	35	68.6%	75.3%	-6.8
Aggressive outreach attempts were documented to confirm immunization status	35	35	100.0%	66.7%	33.3
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Dental needs are addressed for Enrollees aged 21 and above	35	35	100.0%	CNC[1]	CNC[1]
A dental visit occurred during the review period for Enrollees aged 1 to 21	8	34	23.5%	70.0%	-46.5
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	26	26	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees aged 1 to 21	26	26	100.0%	100.0%	0.0
Enrollees aged 9 months to 26 months were tested twice for lead	0	6	0.0%	14.3%	-14.3
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	2	3	66.7%	28.6%	38.1
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	6	6	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	6	6	100.0%	100.0%	0.0

[1] Could not calculate

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	34	35	97.1%	98.6%	-1.5
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	34	35	97.1%	88.9%	8.3
A level of Care Management was determined for the Enrollee	34	34	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	33	33	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	34	34	100.0%	97.3%	2.7
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[1]	100.0%	CNC[1]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%	CNC[1]	CNC[1]

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	35	35	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	33	33	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	33	33	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	4	4	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Limitations

Audit results for the DDD and DCP&P Population should be considered cautiously due to the low sample size of 22 and 68 respectively.

Conclusions

Overall, AGNJ scored 85% and above in the following review categories (**Table 2**):

Outreach (DDD Population) (100%)

- Continuity of Care (DDD Population) (88%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (99%)
- Coordination of Services (DCP&P Population) (100%)
- Continuity of Care (General Population) (100%)

Overall, AGNJ scored below 85% in the following categories **(Table 2)**:

- Identification (General Population) (60%)
- Outreach (General Population) (64%)
- Preventive Services (General Population) (29%)
- Coordination of Services (General Population) (41%)
- Preventive Services (DDD Population) (76 %)
- Preventive Services (DCP&P Population) (81%)

Care Management

Assessment Methodology

The Care Management Annual Assessment review consisted of pre-audit review of documentation provided by Amerigroup New Jersey, Inc. (AGNJ) as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key AGNJ staff via WebEx were held on May 25, 2022, and post-audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on February 10, 2022 and received documentation from the MCOs on February 25, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on February 28, 2022. The audit review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2021, to December 31, 2021.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all he required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met in Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions. Amerigroup received an overall compliance score of 77.0% in 2022. In 2021, the MCO received a score of 80.0%. Review of the elements CM2, CM3, CM5, CM7, CM8, CM13, CM14, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2022. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	-	X	-	X	-	X	-	-
CM3	X	X	-	X	-	-	-	X
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X		-	-	-	-
CM6	X	X		X	-	-	-	X
CM7	-	X	-	X	-	X	-	
CM8	-	X	-	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	-	X	X	-	-	-	X	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	-	X	-	X	-	X	-	
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
TOTAL	**24**	**30**	**23**	**7**	**0**	**5**	**1**	**2**
Compliance Percentage			**77%**					

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 48.8% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 60.0% - Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020).
CM6	**4.6.5.B.1** Identification of Enrollees Who Need Care Management The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**In the 2022 CM file audit the Plan scored for the General Population Enrollee:** 0.0% - IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only).

Element	Contract Language	Reviewer Comments
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 12.8% A Comprehensive Needs Assessment was completed for the Enrollee. 50.6% - Initial outreach to complete a CNA was done. **In the 2022 CM file audit the Plan scored for the DDD Population Enrollees:** 72.7% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 CM file audit the Plan scored for the DDD Population Enrollees** 50.0% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 68.2% **-** The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.

Element	Contract Language	Reviewer Comments
		28.6% - Aggressive outreach attempts were documented to confirm EPSDT status. 28.6% The Care Manager sent EPSDT reminders. 47.4% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 0.0% - Aggressive outreach attempts were documented to confirm immunization status. 20.3% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 10.9% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above. 25.8% - Dental needs are addressed for Enrollees aged 21 and above. 54.5% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 27.3% - Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21. 33.3% - Dental reminders were sent to Enrollees aged 1 to 21. 12.5% -Enrollees aged 9 months to 26 months were tested twice for lead. 66.7% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test 57.1% - Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. **In the 2022 CM file audit the Plan scored for the DDD Population Enrollees:**

Element	Contract Language	Reviewer Comments
		33.3% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 0.0% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 33.3% - Enrollees aged 9 months to 26 months were tested twice for lead. 0.0% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. **In the 2022 CM file audit the Plan scored: for the DCP&P Population Enrollees:** 82.9% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 68.6% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 23.5% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 66.7% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files	**In the 2022 CM file audit the Plan scored for the General Population Enrollees:** 37.5% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

Element	Contract Language	Reviewer Comments
		43.4% - For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services. 37.1% - For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires, and level of self-direction of the Enrollee and/or caregiver.

Recommendations:

For the General Population:

1. **CM2:** AGNJ should ensure that for the Enrollees who were hospitalized, adequate discharge planning is performed.
2. **CM3:** AGNJ should ensure that Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a care manager.
3. **CM6:** AGNJ should ensure that the IHS is completed for the enrollee within 45 days of enrollment (applies to new enrollees only).
4. **CM7:** AGNJ should ensure that Initial outreach to complete a CNA was done and completed for the enrollee.
5. **CM14:** AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, ensure that aggressive outreach attempts are documented to confirm EPSTD status, and the Care Manager sends EPSDT reminders.
6. **CM14:** AGNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status.

7. **CM14:** AGNJ should ensure that appropriate vaccines are administered for Enrollees aged 18 and above and that aggressive outreach attempts are documented to confirm immunization status.
8. **CM14:** AGNJ should ensure that dental needs are addressed for Enrollees aged 21 and above.
9. **CM14:** AGNJ should ensure a dental visit occurred during the review period for Enrollees aged 1 to 21, the Care Manger makes attempts to obtain dental status for enrollees and those dental reminders are sent to enrollees aged 1 to 21.
10. **CM14:** AGNJ should ensure that Enrollees aged 9 months to 26 months are tested twice for lead.
11. **CM14:** AGNJ should ensure that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.
12. **CM14:** AGNJ should ensure that the Care Manager makes attempts to obtain lead status for Enrollees aged 9 months to 72 months and sends lead screening reminders.
13. **CM19:** AGNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).
14. **CM19:** AGNJ should ensure that the Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, discharge planning if hospitalized, pharmacy and other support services as appropriate for the Enrollee and are noted in the Enrollee's case files.

For the DDD Population:

1. **CM7:** AGNJ should ensure that the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
2. **CM8:** AGNJ should ensure that the Care Plan was updated upon a change in the Enrollee's care needs or circumstances.
3. **CM14:** AGNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
4. **CM14:** AGNJ should ensure that the appropriate vaccines have been administered for Enrollees aged 18 and above.
5. **CM14:** AGNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
6. **CM14:** AGNJ that the Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.

For the DCP&P Population:

1. **CM14:** AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
2. **CM14:** AGNJ should ensure that The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
3. **CM14:** AGNJ should ensure that A dental visit occurred during the review period for Enrollees aged 1 to 21.
4. **CM14:** AGNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead.

5. **CM14:** AGNJ should ensure that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Amerigroup New Jersey, Inc.

Review Period August 15, 2021 – June 30, 2022

April 2023

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2021 and January 2022. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 110 cases for Amerigroup New Jersey, Inc. (AGNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 10/25/2021. A sample of 50 high-risk cases with an oversample of four cases was drawn for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 110 cases selected for the MCO, 102 Member files were reviewed and 100 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	26
Group D	Current Members Newly Enrolled to MLTSS	25
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	51
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	2

Population-Specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 86.7% to 99.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	August 2021 – June 2022			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		95.8%		95.8%
Member Outreach	76.0%	100.0%		88.0%
Telephonic Monitoring or Face-to-Face Visits	92.8%	92.9%	85.2%	89.0%
Initial Plan of Care (Including Back-up Plans)	88.2%	85.1%	89.4%	88.0%
Ongoing Care Management	83.9%	91.5%	85.2%	86.7%
Gaps in Care/Critical Incidents	96.2%	100.0%	100.0%	99.0%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 26 files were reviewed for new Members enrolled in managed care and newly eligible for MLTSS (Group C) and 1 file was excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 25 files were further reviewed for compliance in five (5) categories.

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	19	25	76.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	21	25	84.0%
Member was offered the participant direction option during options counseling.[1]	15	15	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	6	7	85.7%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	23	25	92.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

1Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	25	25	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	24	25	96.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	11	15	73.3%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	2	4	50.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this.)	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	15	15	100.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	15	15	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	15	15	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS)	15	15	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	8	25	32.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	9	15	60.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	22	25	88.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	25	25	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-Up Plan, had the Back-Up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	14	15	93.3%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	1	0.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	3	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	2	2	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	1	3	33.3%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 25 files were further reviewed for compliance in all six (6) categories.

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested	23	25	92.0%
Screening for Community Services Assessment was submitted to DoAS by the 10th of the following month.	23	23	100.0%

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	25	25	100.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	24	25	96.0%
Member was offered the participant direction option during options counseling.	25	25	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	7	13	53.8%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	24	25	96.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	25	25	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	12	25	48.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	4	5	80.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to	25	25	100.0%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.			
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	25	25	100.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	25	25	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	25	25	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	25	25	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	1	25	4.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	24	25	96.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	20	25	80.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	25	25	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	24	25	96.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	1	2	50.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	3	4	75.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%

Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 51 files were reviewed for the Members enrolled in managed care and MLTSS prior to the review period (Group E) and 1 file was excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Member Outreach is not assessed for Members in Group E. All 50 files were reviewed for compliance in four (4) categories.

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	49	50	98.0%
Options Counseling was provided to the Member.	49	50	98.0%
Member was offered the participant direction option.	46	50	92.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	16	6.3%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	39	50	78.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the Member's anniversary (from the date of the Initial Plan of Care).	N/A[1]	N/A[1]	N/A[1]
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	41	50	82.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	45	50	90.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	3	3	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	49	50	98.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	50	50	100.0%

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	49	50	98.0%
Care Manager completed an Annual Risk Assessment for the Member (not applicable for Members residing in CARS).	48	50	96.0%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.[2]	50	50	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	48	48	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	15	50	30.0%

[1]Due to the nature of the audit and the timeframe, this was not included in the current audit

[2]The numerator represents the Members that were identified by IPRO as having a potential risk that the Care Manager also identified

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	33	50	66.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	50	50	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	47	50	94.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	1	0.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	8	12	66.7%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	5	5	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	50	50	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	2	2	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	N	D	Rate
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

4. Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #9a (Member's Plan of Care is amended based on change of Member condition), #10 (Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment), #11 (Plans of Care developed using "Person-Centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2021-2022 audit findings. Overall, the MCO's audit results ranged from 98.0% to 100% across all groups for five (5) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: AGNJ

Performance Measure	Group[1]	August 2021 - June 2022		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C			
	Group D			
	Group E			
	Ancillary Group C			
	Ancillary Group D			
	Total			
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E			
	Total			
#9a. Member's Plan of Care is amended based on change of Member condition[4]	Group C	2	2	100.0%
	Group D	4	4	100.0%
	Group E	5	5	100.0%
	Total	11	11	100.0%
#10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment[5]	Group C	25	25	100.0%
	Group D	22	22	100.0%
	Group E			
	Total	47	47	100.0%
#11. Plans of Care developed using "Person-Centered principles"[6]	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	49	50	98.0%
	Total	99	100	99.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	15	15	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	90	90	100.0%
#16. Member training on identifying/reporting critical incidents	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period

[2] This measure was not calculated during this review
[3] This measure was not calculated during this review
[4] Members who did not have a documented change in condition during the study period are excluded from this measure
[5] Group E members are excluded from this measure
[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[7]Members in CARS are excluded from this measure
N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 95.8% in the Assessment category.

Group	8/21 to 6/22
Group C	
Group D	95.8%
Group E	
Combined	95.8%

Member Outreach

Across groups, the MCO had a combined score of 88.0% in the Member Outreach category.

Group	8/21 to 6/22
Group C	76.0%
Group D	100.0%
Group E[1]	
Combined	88.0%

[1]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level of the *Member Outreach category for scores less than 86% include the following:*

- Group C: Amerigroup should ensure that the Care Manager initiates contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.

Telephonic Monitoring or Face-to-Face Visits

Across all three groups, the MCO had a combined score of 89.0% in the Telephonic Monitoring Visits category.

Group	8/21 to 6/22
Group C	92.8%
Group D	92.9%
Group E	85.2%
Combined	89.0%

Opportunities for Improvement for elements at the group level of the *Telephonic Monitoring or Face-to-Face Visits category for scores less than 86% include the following:*

- Group E: Amerigroup should ensure that for Members who selected the participant direction option, application packages are submitted within thirty (30) business days of completion. Amerigroup should ensure Members have a cost neutrality analysis on file during the review period that includes a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 88.0% in the Initial Plan of Care (Including Back-up Plans) category.

Group	8/21 to 6/22
Group C	88.2%
Group D	85.1%
Group E	89.4%
Combined	88.0%

Opportunities for Improvement for elements at the group level of the *Initial Plan of Care (Including Back-up Plans) category for scores less than 86% include the following:*

- Group D: Amerigroup should ensure the Member is assessed for PCA services within 45 days of enrollment into MLTSS. Amerigroup should ensure a PCA re-assessment is completed for changes in the Member's condition or living arrangements. Amerigroup should ensure that the Member file includes a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member has received his/her rights and responsibilities in writing, that these rights and responsibilities are explained to the Member, and that the Member understands them.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 86.7% in the Ongoing Care Management category.

Group	8/21 to 6/22
Group C	83.9%
Group D	91.5%
Group E	85.2%
Combined	86.7%

Opportunities for Improvement for elements at the group level of the *Ongoing Care Management category for scores less than 86% include the following:*

- Group C: Amerigroup should ensure the Member has services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation). Amerigroup should ensure the Care Manager conducts a telephonic visit within 24 hours for an urgent/emergent situation related to a Member's needs, condition, or well-being. Amerigroup should ensure that when a Member file indicates a discharge from an institutional facility to a HCBS, the Care Manager conducts a telephonic visit within ten (10) business days of the documented date of discharge.

- Group E: Amerigroup should ensure the Member has a documented telephonic visit to review Member placement and services during the review period that is held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). Amerigroup should ensure the Care Manager conducts a telephonic visit within 24 hours for an urgent/emergent situation related to a Member's needs, condition, or well-being. Amerigroup should ensure that when a Member file indicates a discharge from an institutional facility to a HCBS, the Care Manager conducts a telephonic visit within ten (10) business days of the documented date of discharge.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 99.0% in the Gaps in Care/Critical Incidents category.

Group	8/21 to 6/22
Group C	96.2%
Group D	100.0%
Group E	100.0%
Combined	99.0%

Performance Measures

Overall, the MCO scored above 86% in all five (5) performance measures.

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

Amerigroup New Jersey, Inc.
Managed Long Term Services and Supports (MLTSS)
2022 Annual Assessment Review of
Care Management

Review Period - July 1, 2021 to June 30, 2022

January 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction……4

Care Management and Continuity of Care……6

List of Tables

Table 1: Rating Scale for the MCO (MLTSS) Annual assessment Review of Care Management…….5

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care…….6-7

Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by AGNJ as evidence of compliance of the standards under review; interviews with key AGNJ staff (held via WebEx on January 10, 2023); and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on October 21, 2022 and received from the MCOs on November 4, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on November 7, 2022. The offsite review team was made up of Carla Zuccarello, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2021 to June 30, 2022. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met and therefore be considered full reviews every year.

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2022 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be submitted once completed.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. AGNJ received an overall compliance score of 100% in 2022. In 2021, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage			**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Amerigroup New Jersey, Inc.

February 2023

IPRO
Better healthcare,
realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30th. Due to COVID-19, the prior review period was from July 1, 2019 through February 29th, 2020. An extension period was included through March 1, 2020 through December 31st, 2020 to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was Janaury 1, 2021 through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 through August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020 where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF/SCNF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Amerigroup New Jersey, Inc. (AGNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on August 14, 2021, and
- The member must have been enrolled as a NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on August 14, 2021, and
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (August 14, 2021).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021 with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months, and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for AGNJ, 102 member files were reviewed and included in the results pertaining to the Plan of Care for Institutional Settings. Two (2) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" (not applicable) were not included in scoring. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting (see Tables 2a-e). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	75	100	75.0%
Documented Review of the Facility Plan of Care by the Care Manager	75	75	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	75	75	100.0%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature**) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS)	3	4	75.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	100	100	100.0%
Care Manager arranged Plan of Care services using both formal and informal supports	100	100	100.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	100	100	100.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	100	100	100.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	100	100	100.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	1	0.0%

Table 2c.

Transition Planning	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	100	100	100.0%
Evidence of the **Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	2	100	2.0%
Member was present at each telephonic visit or was involved from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in a telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	100	100	100.0%
Timely telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	95	100	95.0%
Members requiring coordination of care had coordination of care by the Care Manager	98	100	98.0%
Care Manager explained and discussed any payment liability with the Member if a member had any payment liability for the NF/SCNF admission	6	100	6.0%

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	98	100	98.0%
Care Manager reviewed the Member's Rights and Responsibilities	100	100	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	100	100	100.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	99	100	99.0%

CNC: Could not calculate

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period	N/A		
Member was admitted to an NF/SCNF during the review period	N/A		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	N/A	N/A	N/A

N/A: Not Applicable (PASRR questions were removed this year; Due to the COVID-19 pandemic, face-to-face visits were placed on hold)

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for AGNJ, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3** and **Table 4**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

NF/SCNF Members Transitioned to HCBS	Review Period (January 1, 2021- August 14, 2021)		
	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC

CNC: Could not calculate

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF/SCNF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: AGNJ

Performance Measure	Group	January 2021 – August 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	3	4	75.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	3	4	75.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	100	100	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	100	100	100.0%
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	1	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	1	0.0%
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	100	100	100.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	100	100	100.0%
#16. Member training on identifying/reporting critical incidents	Group 1	99	100	99.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	99	100	99.0%

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

Limitations

The annual NF/SCNF CM Audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. During the 2021 NF/SCNF CM Audit the MCOs were only evaluated based on scores from the review period (period through which they could conduct normal business activities) not the expansion period. The 2021 NF CM review period changed from a full year review to a partial year review beginning January 1, 2021 and ending August 14, 2021.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (100%)
- MLTSS Plan of Care on file (100%)
- Care Managers used a person-centered approach (100%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (100%)
- Plan of Care that was given to the member contained goals that met all the criteria (100%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (100%)
- Member was identified for transfer to HCBS and was offered options (100%)
- Member was present at each telephonic visit (100%)
- Timely Telephonic Review of Member Placement and Services (95.0%)
- Members requiring coordination of care had coordination of care (98.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (98.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100%)
- Member and/or representative had training on how to report a critical incident (99.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (75.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (75.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (2.0%)
- Care Manager explained and discussed any payment liability (6.0%)

Recommendations for audit elements include the following:

Amerigroup's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The Care Manager should ensure that Member's Plan of Care is reviewed, revised if applicable for any significant changes. The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. Amerigroup should ensure MLTSS Care Managers is to discuss payment.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (75.0%)
- #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

Recommendations for MLTSS Performance Measures include the following:

Amerigroup's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix D: HNJH 2022 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Horizon NJ Health
Review Period: January 1, 2021 – December 31, 2021

November 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction 4

Methodology 4

Pre-Audit Activities 4

Audit Activities 6

Audit Results 6

GP Population Findings 7

DDD Population Findings 10

DCP&P Population Findings 13

Conclusions 15

Care Management Annual Assessment 16

Care Management 16

Recommendations 22

List of Tables

Table 1: Sampling Methodology 5
Table 2: Aggregate Results by Category 6
Table 3: Identification – GP Population 7
Table 4: Outreach – GP Population 8
Table 5: Preventive Services – GP Population 8
Table 6: Continuity of Care – GP Population 9
Table 7: Coordination of Services – GP Population 10
Table 8: Outreach – DDD Population 10
Table 9: Preventive Service – DDD Population 11
Table 10: Continuity of Care – DDD Population 12
Table 11: Coordination of Services – DDD Population 12
Table 12: Outreach – DCP&P Population 13
Table 13: Preventive Services – DCP&P Population 13
Table 14: Continuity of Care – DCP&P Population 14
Table 15: Coordination of Services – DCP&P Population 14
Table 16: Rating Scale for the Annual Care Management Assessment 16
Table 17: Summary of Findings for Care Management Annual Assessment 17
Table 18: Findings for Deficient Care Management Elements 18
Table 19: Findings for Resolved Deficiencies for Care Management Elements 22

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 341 cases for Horizon NJ Health (HNJH), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was more than 100 Enrollees (140). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (91).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599, 49499 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2021	>= 3 months as of 12/31/2021	>= 3 months and < 18 years as of 12/31/2021
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2021 to 7/1/2021	Initial enrollment between 1/1/2021 and 12/31/2021	Initial enrollment between 1/1/2021 and 12/31/2021
Current Enrollment	Enrolled as of 12/31/2021	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2021 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's 2021 audit results ranged from 52% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP 2021 (n=100)	GP 2020 (n=100)	PPD[2]	DDD 2021 (n=71)	DDD 2020 (n=92)	PPD[2]	DCP&P 2021 (n=86)	DCP&P 2020 (n=100)	PPD[2]
Identification[1]	57%	88%	-31						
Outreach	57%	91%	-33	97%	98%	-1	99%	94%	6
Preventive Services	62%	84%	-23	69%	75%	-6	69%	86%	-17
Continuity of Care	52%	71%	-19	81%	84%	-3	100%	90%	10
Coordination of Services	72%	79%	-6	100%	100%	0	100%	100%	0

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

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 1 Enrollee was a new Enrollee, and 99 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	0	CNC[1]	25.0%	CNC[1]
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)	1	1	100.0%	33.3%	66.7
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only)*	0	1	0.0%	90.9%	-90.9
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	1	1	0.0%[2]	100.0%	-100.0
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020) *	32	99	32.3%	16.9%	15.5
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020)	29	68	57.4%[2]	95.9%	-38.6
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management) *	26	39	66.7%	89.2%	-22.5

**Not Included in aggregate score calculation.*

[1] Could not calculate.

[2] Percentage rate is indicative of an inverse percentage.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (55).

Table 4: Outreach – GP Population

Outreach	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	22	55	40.0%	94.7%	-54.7
The outreach for CNA was timely within 30 days of the identification of CM needs	22	22	100.0%	86.1%	13.9
Outreach was successful (even if the Enrollee declines to complete the CNA) *	19	22	86.4%	58.3%	28.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	3	3	100.0%	64.1%	35.9
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	10	19	52.6%	45.2%	7.4
The Enrollee declined Care Management*	11	22	50.0%	36.1%	13.9

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (89).

Table 5: Preventive Services – GP Population

Preventive Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	22	25	88.0%	100.0%	-12.0
Aggressive outreach attempts were documented to confirm EPSDT status	3	3	100.0%	CNC[1]	CNC[1]
The Care Manager sent EPSDT reminders	3	3	100.0%	CNC[1]	CNC[1]
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	19	24	79.2%	100.0%	-20.8
Aggressive outreach attempts were documented to confirm immunization status	1	5	20.0%	CNC[1]	CNC[1]
Appropriate vaccines have been administered for Enrollees aged 18 and above	28	65	43.1%	78.1%	-35.0
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	8	37	21.6%	100.0%	-78.4
Dental needs are addressed for Enrollees aged 21 and above	64	64	100.0%	90.6%	8.2
A dental visit occurred during the review period for Enrollees aged 1 to 21	13	22	59.1%	25.0%	34.1
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	3	9	33.3%	100.0%	-66.7
Dental reminders were sent to Enrollees aged 1 to 21	5	9	55.6%	100.0%	-44.4
Enrollees aged 9 months to 26 months were tested twice for lead	1	8	12.5%	66.7%	-54.2
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	3	0.0%	0.0%	0.0
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	2	3	66.7%	100.0%	-33.3
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	5	7	71.4%	100.0%	-28.6

[1] Could not calculate

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

This section includes Enrollees with identified Care Management needs who accept Care Management, or who were already in Care Management (76). If members decline Care Management afterwards, they will be removed from this section.

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
A Comprehensive Needs Assessment was completed for the Enrollee	10	76	13.2%	41.7%	-28.5
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.)[2]	6	10	60.0%	69.2%	-9.2
A level of Care Management was determined for the Enrollee	10	10	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	8	89	9.0%	5.6%	3.4
A Care Plan was completed for the Enrollee that included all required components	23	23	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	8	10	80.0%	62.5%	17.5
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	23	23	100.0%	100.0%	-0.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	100.0%	CNC[1]

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (89).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	52	89	58.4%	25.0%	33.4
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	44	61	72.1%	100.0%	-27.9
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	43	60	71.7%	100.0%	-28.3
For Enrollees who were hospitalized, adequate discharge planning was performed	49	50	98.0%	100.0%	-2.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DDD Population Findings

A total of 91 files were reviewed for the DDD Population with 20 exclusions.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	71	71	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	67	71	94.4%	95.7%	-1.3
Outreach was successful (even if the Enrollee declines to complete the CNA) *	30	71	42.3%	65.2%	-23.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	26	38	68.4%	85.0%	-16.6
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	30	0.0%	3.3%	-3.3
The Enrollee declined Care Management*	4	71	5.6%	0.0%	5.6

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	34	42	81.0%	67.9%	13.1
Aggressive outreach attempts were documented to confirm EPSDT status	8	8	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	8	8	100.0%	100.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	10	32	31.3%	79.5%	-48.2
Aggressive outreach attempts were documented to confirm immunization status	21	32	65.6%	100.0%	-34.4
Appropriate vaccines have been administered for Enrollees aged 18 and above	7	39	17.9%	45.3%	-27.3
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	31	32	96.9%	100.0%	-3.1
Dental needs are addressed for Enrollees aged 21 and above	59	71	83.1%	69.4%	13.7
A dental visit occurred during the review period for Enrollees aged 1 to 21	22	41	53.7%	55.4%	-1.7
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	19	19	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees aged 1 to 21	19	19	100.0%	100.0%	0.0
Enrollees aged 9 months to 26 months were tested twice for lead	0	6	0.0%	100.0%	-100.0
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	2	5	40.0%	CNC[1]	CNC[1]
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	6	6	100.0%	CNC[1]	CNC[1]
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	6	6	100.0%	CNC[1]	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	46	67	68.7%	64.1%	4.5
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	44	87	50.6%	39.0%	11.6
A level of Care Management was determined for the Enrollee	46	46	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	0	67	0.0%	0.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	46	46	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	46	46	100.0%	98.3%	1.7
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	2	2	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC[1]	CNC[1]

**Not Included in aggregate score calculation.*

[1] Could not calculate.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	67	67	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	17	17	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	8	8	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	5	5	100.0%	100.0%	0.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2021 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	CNC[1]	100.0%	CNC[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	CNC[1]	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DCP&P Population Findings

A total of 140 files were reviewed for the DCP&P Population. (54) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	86	86	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	85	86	98.8%	87.0%	11.8
Outreach was successful (even if the Enrollee declines to complete the CNA) *	37	86	43.0%	98.0%	-55.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	41	50	82.0%	98.2%	-16.2
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	37	0.0%	0.0%	0.0

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	85	86	98.8%	98.0%	0.8
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	1	1	100.0%	100.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	51	86	59.3%	86.0%	-26.7
Aggressive outreach attempts were documented to confirm immunization status	33	86	38.4%	100.0%	-61.6
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Dental needs are addressed for Enrollees aged 21 and above	85	86	98.8%	CNC[1]	CNC[1]
A dental visit occurred during the review period for Enrollees aged 1 to 21	42	86	48.8%	84.4%	-35.6
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	43	44	97.7%	100.0%	-2.3
Dental reminders were sent to Enrollees aged 1 to 21	42	44	95.5%	100.0%	-4.5
Enrollees aged 9 months to 26 months were tested twice for lead	2	52	3.8%	5.0%	-1.2
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	5	34	14.7%	33.3%	-18.6
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	48	50	96.0%	100.0%	-4.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	49	50	98.0%	100.0%	-2.0

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	85	86	98.8%	100.0%	-1.2
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [1]	85	86	98.8%	62.0%	36.8
A level of Care Management was determined for the Enrollee	85	85	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	85	85	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	85	85	100.0%	99.0%	1.0
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	13	14	92.8%	100.0%	7.7
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	4	4	100.0%	100.0%	0.0

**Not Included in aggregate score calculation.*

[1] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	86	86	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	48	48	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	28	28	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	11	11	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Limitations

No limitations are noted.

Conclusions

Overall, HNJH scored 85% and above in the following review categories (**Table 2**):

- Outreach (DDD Population) (97%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (99%)
- Continuity of Care (DCP&P Population) (100%)
- Coordination of Services (DCP&P Population) (100%)

Overall, HNJH scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (57%)
- Outreach (General Population) (57%)
- Preventive Services (General Population) (62%)
- Continuity of Care (General Population) (80%)
- Coordination of Services (General Population) (72%)
- Preventive Services (DDD Population) (69%)
- Continuity of Care (DDD Population) (81%)
- Preventive Services (DCP&P Population) (69%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment review consisted of pre-audit review of documentation provided by Horizon NJ Health (HNJH), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key HNJH staff via WebEx were held on May 23, 2022, and post-audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on February 10, 2022 and received documentation from the MCOs on February 25, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on February 28, 2022. The audit review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2021, to December 31, 2021.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met in Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions. HNJH received an overall compliance score of 83% in 2022. In 2021, the MCO received a score of 83%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM13, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2022. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Year	Subject to review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	X	X	X	-	-	-	-	-
CM3	X	X	-	X	-	-	-	X
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	-	X	X	-	-	-	X	-
CM7	-	X	-	X	-	X	-	-
CM8	-	X	-	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	X	X	X	-	-	-	-	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	-	X	-	X	-	X	-	-
CM20	X	X	X	-	-	-	-	-
CM21	X	x	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
TOTAL	**25**	**30**	**25**	**5**	**0**	**4**	**1**	**1**
Compliance Percentage			**83%**					

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2022 CM file audit the MCO scored: for the General Population Enrollees:** 57.4% Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020).
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 CM file audit the MCO scored: for the General Population Enrollees:** 13.2% **-** A Comprehensive Needs Assessment was completed for the Enrollee. 60.0% - Initial outreach to complete a CNA was done. **In the 2022 CM file audit the Plan scored: for the DDD Population Enrollees:** 68.4%- When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment. 68.7% - Comprehensive Needs Assessment (CNA) was done and includes all required elements. 50.6% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). **In the 2022 CM file audit the Plan scored: for the DCP&P Population Enrollees:** 82.0% - When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be	**In the 2022 CM file audit the MCO scored: for the General Population Enrollees:** 80.0% The Care Plan was developed within 30 days of CNA Completion.

Element	Contract Language	Reviewer Comments
	culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 79.2% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 20.0% - Aggressive outreach attempts were documented to confirm immunization status. 43.1% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 21.6% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above. 59.1% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 33.3% - Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21. 55.6% - Dental reminders were sent to Enrollees aged 1 to 21. 12.5% - Enrollees aged 9 months to 26 months were tested twice for lead. 0.0% - enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. 66.7% - Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months.

Element	Contract Language	Reviewer Comments
		71.4% - Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. **In the 2022 CM file audit the Plan scored: for the DDD Population Enrollees:** 81% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 31.3% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 65.6% - Aggressive outreach attempts were documented to confirm immunization status. 17.9% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 83.1% - Dental needs are addressed for Enrollees aged 21 and above. 53.7% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 40.0% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. **In the 2022 CM file audit the Plan scored: for the DCP&P Population Enrollees:** 59.3% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 38.4% - Aggressive outreach attempts were documented to confirm immunization status.

Element	Contract Language	Reviewer Comments
		48.8% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 3.8% - Enrollees aged 9 months to 26 months were tested twice for lead. 14.7% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 58.4% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD). 72.1% - For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services. 71.7% - For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.

Recommendations

For the General Population:

1. **CM3:** HNJH should ensure that enrollees identified by IPRO as having Potential CM needs during the review period that the MCO did not identify (applied to existing enrollees enrolled prior to 11/16/2020.)
2. **CM7:** HNJH should ensure that the initial outreach to complete a Comprehensive Needs Assessment is done and completed for the enrollee.
3. **CM8:** HNJH should ensure that the Care Plans are developed within 30 days of the CNA completion and HNJH should ensure that upon a change in care needs or circumstances, and that the Care Plan is updated.
4. **CM14:** HNJH should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status.
5. **CM14:** HNJH should ensure that appropriate vaccines have been administered for Enrollees aged 18 and above and aggressive outreach attempts were documented to confirm immunization status for Enrollees.
6. **CM14:** HNJH should ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21, the Care Manager makes attempts to obtain dental status for Enrollees and Dental reminders are sent to Enrollees aged 1 to 21.
7. **CM14:** HNJH should ensure that Enrollees aged 9 months to 26 months are tested twice for lead.
8. **CM14:** HNJH should ensure that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
9. **CM14:** HNJH should ensure that Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months and the Care Manager sends lead screening reminders for Enrollees.
10. **CM19:** HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).
11. **CM19:** HNJH should ensure that for Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services and the Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.

For the DDD Population:

1. **CM7:** HNJH should ensure that the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment), the CNA is done and includes all required elements and when the initial outreach is unsuccessful, aggressive outreach attempts are documented and done within 45 days of the Enrollee's enrollment.
2. **CM14:** HNJH should ensure the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
3. **CM14:** HNJH should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status.
4. **CM14:** HNJH should ensure that appropriate vaccines have been administered for Enrollees aged 18 and above
5. **CM14:** HNJH should ensure that dental needs are addressed for enrollees aged 21 and above, that a dental visit occurred during review period of Enrollees aged 1 to 21.
6. **CM14:** HNJH should ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
7. **CM14:** HNJH should ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

For DCP&P Population:

1. **CM 7:** HNJH should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment.
2. **CM14:** HNJH should ensure that immunizations are up to date for Enrollee's aged 0-18, confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status.
3. **CM14:** HNJH should ensure that a dental visit occurred during review period for Enrollee's aged 1-21.
4. **CM14:** HNJH should ensure that Enrollees aged 9-26 months are tested twice for lead.
5. **CM14:** HNJH should ensure that Enrollees who have never previously been tested for lead before 24 months of age received a blood test.

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Horizon New Jersey Health

Review Period August 15, 2021 – June 30, 2022

April 2023

Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2021 and January 2022. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 110 cases for Horizon New Jersey Health (HNJH), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care, and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 9/2/2021. A sample of 50 high-risk cases with an oversample of four cases was drawn for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 110 cases selected for the MCO, 100 member files were reviewed and 100 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	25
Group D	Current Members Newly Enrolled to MLTSS	25
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	50
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	0

Population-Specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 90.0% to 100% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	August 2021 - June 2022			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		100.0%		100.0%
Member Outreach	92.0%	88.0%		90.0%
Telephonic Monitoring or Face-to-Face Visits	96.5%	93.3%	91.6%	93.3%
Initial Plan of Care (Including Back-up Plans)	92.3%	91.0%	97.6%	94.8%
Ongoing Care Management	91.1%	89.9%	96.3%	93.1%
Gaps in Care/Critical Incidents	100.0%	100.0%	99.0%	99.5%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial Member Outreach is not assessed for members in Group E because Group E members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 25 files were reviewed for new members enrolled in managed care and newly eligible for MLTSS (Group C). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 25 files were further reviewed for compliance in five (5) categories.

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	23	25	92.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	25	25	100.0%
Member was offered the participant direction option.[1]	23	23	100.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	15	15	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	21	25	84.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

1Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	20	25	80.0%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	17	23	73.9%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	23	23	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	23	23	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	19	23	82.6%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	2	0.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	25	25	100.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	20	23	87.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	2	2	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	24	25	96.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	25	25	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	19	23	82.6%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	1	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	2	2	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	25	25	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 25 files were further reviewed for compliance in all six (6) categories.

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	25	25	100.0%
Screening for Community Services Assessment was submitted to DoAS by the 10th of the following month.	25	25	100.0%

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	22	25	88.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	24	25	96.0%
Member was offered the participant direction option.[1]	19	21	90.5%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	6	8	75.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	23	25	92.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	1	100.0%

1Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.	22	25	88.0%
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	8	21	38.1%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented). Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, (the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	21	21	100.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	21	21	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	18	21	85.7%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	2	2	100.0%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	25	25	100.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	21	21	100.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	22	25	88.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	25	25	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	16	21	76.2%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	2	4	50.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	3	3	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	25	25	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 50 files were reviewed for the members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Member Outreach is not assessed for members in Group E. All 50 files were reviewed for compliance in four (4) categories.

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	50	50	100.0%
Options Counseling was provided to the Member.	50	50	100.0%
Member was offered the participant direction option.	42	50	84.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	2	50.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	42	50	84.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the member's anniversary (from the date of the Initial Plan of Care).	N/A[1]	N/A[1]	N/A[1]
Member file included documentation of coordination with the member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the members' HCBS providers at least annually to discuss the providers' reviews of the member's needs and status and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	5	6	83.3%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals; this includes the requirement that the member and/or member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	49	50	98.0%
Back-up Plan included actions that a member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	49	49	100.0%
Care Manager completed an Annual Risk Assessment for the member (not applicable for Members residing in CARS.	48	50	96.0%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.[2]	49	50	98.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	7	12	58.3%

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the member and dated during the review period, stating that the member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the member, and that the member understood them.	49	50	98.0%

[1]Due to the nature of the audit and the timeframe, this was not included in the current audit

[2]The numerator represents the Members that were identified by IPRO as having a potential risk that the Care Manager also identified

	August 2021 - June 2022		
Ongoing Care Management	N	D	Rate
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review member placement and services should occur at least every 90 days for members in the community setting and at least every 180 days for members in CARS from the date of the initial visit).	48	50	96.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the member agreed with the Plan of Care, and that the member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	50	50	100.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the member's right to file an appeal.	0	0	N/A
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the member at least on a quarterly basis (not applicable for Members residing in CARS).	47	49	95.9%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	1	3	33.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the member and/or authorized representative.	8	8	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the member.	50	50	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the member immediately to resolve the issue related to the gap in service.	1	2	50.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

4. Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #9a (Member's Plan of Care is amended based on change of member condition), #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment), #11 (Plans of Care developed using "Person-Centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training

on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2021-2022 audit findings. Overall, the MCO's audit results ranged from 98.9% to 100% across all groups for five (5) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: HNJH

Performance Measure	Group[1]	August 2021 - June 2022		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C			
	Group D			
	Group E			
	Ancillary Group C			
	Ancillary Group D			
	Total			
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E			
	Total			
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	2	2	100.0%
	Group D	3	3	100.0%
	Group E	8	8	100.0%
	Total	13	13	100.0%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	24	24	100.0%
	Group D	24	24	100.0%
	Group E			
	Total	48	48	100.0%
#11. Plans of Care developed using "Person-Centered principles"[6]	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	23	23	100.0%
	Group D	21	21	100.0%
	Group E	49	50	98.0%
	Total	93	94	98.9%
#16. Member training on identifying/reporting critical incidents	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period

[2]This measure was not calculated during this review

[3]This measure was not calculated during this review

[4]Members who did not have a documented change in condition during the study period are excluded from this measure

[5] Group E members are excluded from this measure

[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC

[7]Members in CARS are excluded from this measure

N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 100.0% in the Assessment category.

Group	8/21 to 6/22
Group C	
Group D	100.0%
Group E	
Combined	100.0%

Member Outreach

Across groups, the MCO had a combined score of 90.0% in the Member Outreach category.

Group	8/21 to 6/22
Group C	92.0%
Group D	88.0%
Group E[1]	
Combined	90.0%

[1]Initial Member Outreach is not assessed for members in Group E because Group E members are not new to MLTSS

Telephonic Monitoring or Face-to-Face Visits

Across all three groups, the MCO had a combined score of 93.3% in the Telephonic Monitoring Visits category.

Group	8/21 to 6/22
Group C	96.5%
Group D	93.3%
Group E	91.6%
Combined	93.3%

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 94.8% in the Initial Plan of Care (Including Back-up Plans) category.

Group	8/21 to 6/22
Group C	92.3%
Group D	91.0%
Group E	97.6%
Combined	94.8%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 93.1% in the Ongoing Care Management category.

Group	8/21 to 6/22
Group C	91.1%
Group D	89.9%
Group E	96.3%
Combined	93.1%

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 99.5% in the Gaps in Care/Critical Incidents category.

Group	8/21 to 6/22
Group C	100.0%
Group D	100.0%
Group E	99.0%
Combined	99.5%

Performance Measures

Overall, The MCO scored above 86% in all the five (5) Performance Measures.

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

Horizon New Jersey Health
Managed Long Term Services and Supports (MLTSS)
2022 Annual Assessment Review of
Care Management

Review Period - July 1, 2021 to June 30, 2022

January 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction……4

Care Management and Continuity of Care……6

List of Tables

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management……5

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care……6

Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jersey Health (HNJH) as evidence of compliance of the standards under review; interviews with key HNJH staff (held via WebEx on January 12, 2023) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on October 21, 2022 and received from the MCOs on November 4, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on November 7, 2022. The offsite review team was made up of Carla Zuccarello, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2021, to June 30, 2022. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2022 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. HNJH received an overall compliance score of 100% in 2022. In 2021, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage			**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
Horizon New Jersey Health

February 2023

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30th. Due to COVID-19, the prior review period was from July 1, 2019 through February 29th, 2020. An extension period was included through March 1, 2020 through December 31st, 2020 to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was Janaury 1, 2021 through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 through August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020 where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF/SCNF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Horizon New Jersey Health (HNJH), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on August 14, 2021, and
- The member must have been enrolled as n NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on August 14, 2021, and
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (August 14, 2021).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021 with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months, and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for HNJH, 102 member files were reviewed and included in the results pertaining to the Plan of Care for Institutional Settings. Two (2) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" (not applicable) were not included in scoring. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting (see **Tables 2a-e).** Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	64	100	64.0%
Documented Review of the Facility Plan of Care by the Care Manager	64	64	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	63	64	98.4%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature**) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS)	1	6	16.7%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	99	100	99.0%
Care Manager arranged Plan of Care services using both formal and informal supports	99	100	99.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	99	100	99.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	99	100	99.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	99	100	99.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	2	0.0%

CNC: Could not calculate

Table 2c.

Transition Planning	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	100	100	100.0%
Evidence of the **Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	8	100	8.0%
Member was present at each telephonic visit or was involved from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in a telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	100	100	100.0%
Timely telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	100	100	100.0%
Members requiring coordination of care had coordination of care by the Care Manager	100	100	100.0%
Care Manager explained and discussed any payment liability with the Member if a member had any payment liability for the NF/SCNF admission	55	100	55.0%

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	99	100	99.0%
Care Manager reviewed the Member's Rights and Responsibilities	99	100	99.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	99	100	99.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	96	100	96.0%

CNC: Could not calculate

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period	N/A		
Member was admitted to an NF/SCNF during the review period	N/A		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	N/A	N/A	N/A

N/A: Not Applicable (PASRR questions were removed this year; Due to the COVID-19 pandemic, face-to-face visits were placed on hold)

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for HNJH, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 3 and Table 4, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

NF/SCNF Members Transitioned to HCBS	Review Period (January 1, 2021-August 14, 2021)		
	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC

CNC: Could not calculate

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	Review Period (January 1, 2021-August 14, 2021)		
	Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF/SCNF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: HNJH

Performance Measure	Group	January 2021 – August 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	1	6	16.7%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	1	6	16.7%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	99	100	99.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	99	100	99.0%
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	2	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	2	0.0%
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	99	100	99.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	99	100	99.0%
#16. Member training on identifying/reporting critical incidents	Group 1	96	100	96.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	96	100	96.0%

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

Limitations

The annual NF/SCNF CM Audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. During the 2021 NF/SCNF CM Audit the MCOs were only evaluated based on scores from the review period (period through which they could conduct normal business activities) not the expansion period. The 2021 NF CM review period changed from a full year review to a partial year review beginning January 1, 2021 and ending August 14, 2021.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (100%)
- MLTSS Plan of Care on file (98.4%)
- Care Managers used a person-centered approach (99.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (99.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (99.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (99.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (99.0%)
- Member was identified for transfer to HCBS and was offered options (100%)
- Member was present at each telephonic visit (100%)
- Timely Telephonic Review of Member Placement and Services (100%)
- Members requiring coordination of care had coordination of care (100%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (99.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (99.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (99.0%)
- Member and/or representative had training on how to report a critical incident (96.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (64.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (16.7%)
- Updated Plan of Care for a Significant Change (0.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (8.0%)
- Care Manager explained and discussed any payment liability (55.0%)

Recommendations for audit elements include the following:

Horizon's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The Care Manager should ensure that Member's Plan of Care is reviewed, revised if applicable for any significant changes. The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. Horizon should ensure the MLTSS Care Managers discuss payment liability.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (16.7%)
- #9a. Member's Plan of Care is amended based on change of member condition (0.0%)

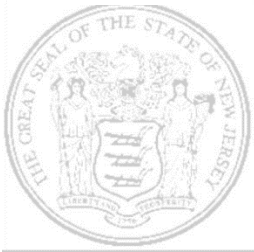
Recommendations for MLTSS Performance Measures include the following:

HNJH's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix E: UHCCP 2022 Core Medicaid and MLTSS Care Management Audits



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
UnitedHealthcare Community Plan
Review Period: January 1, 2021 – December 31, 2021

November 2022

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction 4

Methodology 4

Pre-Audit Activities 4

Audit Activities 6

Audit Results 6

GP Population Findings 6

DDD Population Findings 10

DCP&P Population Findings 13

Conclusions 15

Care Management Annual Assessment 16

Care Management 16

Recommendations 22

List of Tables

Table 1: Sampling Methodology 5
Table 2: Aggregate Results by Category 6
Table 3: Identification – GP Population 6
Table 4: Outreach – GP Population 7
Table 5: Preventive Services – GP Population 8
Table 6: Continuity of Care – GP Population 9
Table 7: Coordination of Services – GP Population 10
Table 8: Outreach – DDD Population 10
Table 9: Preventive Service – DDD Population 11
Table 10: Continuity of Care – DDD Population 12
Table 11: Coordination of Services – DDD Population 12
Table 12: Outreach – DCP&P Population 13
Table 13: Preventive Services – DCP&P Population 13
Table 14: Continuity of Care – DCP&P Population 14
Table 15: Coordination of Services – DCP&P Population 14
Table 16: Rating Scale for the Annual Care Management Assessment 16
Table 17: Summary of Findings for Care Management Annual Assessment 17
Table 18: Findings for Deficient Care Management Elements 18

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 198 cases for UnitedHealthcare Community Plan (UHCCP), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (66). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (22).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599, 49499 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2021	>= 3 months as of 12/31/2021	>= 3 months and < 18 years as of 12/31/2021
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2021 to 7/1/2021	Initial enrollment between 1/1/2021 and 12/31/2021	Initial enrollment between 1/1/2021 and 12/31/2021
Current Enrollment	Enrolled as of 12/31/2021	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2021 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's 2021 audit results ranged from 42% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP 2021 (n=100)	GP 2020 (n=100)	PPD[2]	DDD 2021 (n=18)	DDD 2020 (n=2)	PPD[2]	DCP&P 2021 (n=34)	DCP&P 2020 (n=25)	PPD[2]
Identification[1]	81%	88%	-6						
Outreach	83%	90%	-7	100%	100%	0	100%	96%	4
Preventive Services	42%	49%	-7	73%	64%	9	70%	83%	-13
Continuity of Care	65%	74%	-9	83%	71%	12	100%	97%	3
Coordination of Services	78%	98%	-20	100%	100%	0	100%	100%	0

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

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, there were no new Enrollees, and 100 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	0	0	CNC[1]	0.0%	CNC[1]
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were	0	0	CNC[1]	0.0%	CNC[1]

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
done within 45 days of the Enrollee's enrollment (applies to new Enrollees only)					
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) *	0	0	CNC[1]	50.0%	CNC[1]
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	0	CNC[1]	100.0%	CNC[1]
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020) *	25	100	25.0%	31.3%	-6.3
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020)	14	75	81.3%[2]	90.9%	-9.6
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management) *	40	61	65.6%	51.5%	14.1

**Not Included in aggregate score calculation*

[1] Could not calculate.

[2] Percentage rate is indicative of an inverse percentage.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (54).

Table 4: Outreach – GP Population

Outreach	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	39	54	72.2%	91.7%	-19.4
The outreach for CNA was timely within 30 days of the identification of CM needs	38	39	97.4%	87.9%	9.6
Outreach was successful (even if the Enrollee declines to complete the CNA) *	23	39	59.0%	72.7%	-13.8
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	14	16	87.5%	69.2%	18.3
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	7	23	30.4%	16.7%	13.8
The Enrollee declined Care Management*	10	39	25.6%	12.1%	13.5

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to thi**Preventive Services**

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (89).

Table 5: Preventive Services – GP Population

Preventive Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	26	26	100.0%	100.0%	0.0
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC[1]	CNC[1]	CNC[1]
The Care Manager sent EPSDT reminders	0	0	CNC[1]	CNC[1]	CNC[1]
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	13	26	50.0%	25.0%	25.0
Aggressive outreach attempts were documented to confirm immunization status	4	13	30.8%	33.3%	-2.5
Appropriate vaccines have been administered for Enrollees aged 18 and above	19	63	30.2%	65.1%	-35.0
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	19	42	45.2%	6.7%	38.6
Dental needs are addressed for Enrollees aged 21 and above	22	63	34.9%	53.5%	-18.6
A dental visit occurred during the review period for Enrollees aged 1 to 21	9	26	34.6%	28.6%	6.0
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	8	17	47.1%	60.0%	-12.9
Dental reminders were sent to Enrollees aged 1 to 21	8	17	47.1%	60.0%	-12.9
Enrollees aged 9 months to 26 months were tested twice for lead	0	10	0.0%	25.0%	-25.0
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	9	11.1%	0.0%	11.1
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	4	7	57.1%	33.3%	23.8
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	5	10	50.0%	33.3%	16.7

[1] Could not calculate

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

This section includes Enrollees with identified Care Management needs who accept Care Management, or who were already in Care Management (67). If Enrollees decline Care Management afterwards, they will be removed from this section.

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
A Comprehensive Needs Assessment was completed for the Enrollee	23	67	34.3%	62.7%	-28.4
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and existing Enrollees not already enrolled in Care Management.[2]	9	24	37.5%	82.4%	-44.9
A level of Care Management was determined for the Enrollee	18	24	75.0%	28.1%	46.9
The Enrollee is in Community Based Care Management (CBCM)*	27	89	30.3%	49.0%	-18.7
A Care Plan was completed for the Enrollee that included all required components	24	26	92.3%	100.0%	-7.7
The Care Plan was developed within 30 days of CNA Completion	18	23	78.3%	88.9%	-10.6
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	24	27	88.9%	88.9%	0.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	6	6	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA" for this category.

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (89).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	54	89	60.7%	98.0%	-37.4
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	30	30	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	26	26	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	44	52	84.6%	95.0%	-10.4

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DDD Population Findings

A total of 22 files were reviewed for the DDD Population with 4 exclusions.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	18	18	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	18	18	100.0%	100.0%	0.0
Outreach was successful (even if the Enrollee declines to complete the CNA) *	11	18	61.1%	50.0%	11.1
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	7	7	100.0%	100.0%	0.0
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	11	0.0%	0.0%	0.0
The Enrollee declined Care Management*	0	18	0.0%	0.0%	0.0

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	4	5	80.0%	50.0%	30.0
Aggressive outreach attempts were documented to confirm EPSDT status	1	1	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	1	1	100.0%	100.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	0	2	0.0%	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status	2	2	100.0%	CNC[1]	CNC[1]
Appropriate vaccines have been administered for Enrollees aged 18 and above	3	16	18.8%	0.0%	18.8
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	13	13	100.0%	100.0%	0.0
Dental needs are addressed for Enrollees aged 21 and above	17	18	94.4%	CNC[1]	CNC[1]
A dental visit occurred during the review period for Enrollees aged 1 to 21	5	5	100.0%	0.0%	100.0
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	0	0	CNC[1]	100.0%	CNC[1]
Dental reminders were sent to Enrollees aged 1 to 21	0	0	CNC[1]	100.0%	CNC[1]
Enrollees aged 9 months to 26 months were tested twice for lead	0	0	CNC[1]	CNC[1]	CNC[1]
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	0	CNC[1]	CNC[1]	CNC[1]
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	0	0	CNC[1]	CNC[1]	CNC[1]
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	0	0	CNC[1]	CNC[1]	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	12	18	66.7%	50.0%	16.7
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	12	22	54.5%	100.0%	-45.5
A level of Care Management was determined for the Enrollee	12	12	100.0%	100.0%	0.0
The Enrollee is in Community Based Care Management (CBCM)*	5	18	27.8%	0.0%	27.8
A Care Plan was completed for the Enrollee that included all required components	12	12	100.0%	50.0%	50.0
The Care Plan was developed within 30 days of CNA Completion	12	12	100.0%	50.0%	50.0
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	1	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%	CNC[1]	CNC[1]

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	18	18	100.0%	100.0%	0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	15	15	100.0%	100.0%	0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	12	12	100.0%	100.0%	0
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%	CNC[1]	CNC[1]
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2021 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	CNC[1]	CNC[1]	CNC[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	CNC[1]	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DCP&P Population Findings

A total of 66 files were reviewed for the DCP&P Population. (32) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	34	34	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	34	34	100.0%	92.0%	8.0
Outreach was successful (even if the Enrollee declines to complete the CNA) *	34	34	100.0%	100.0%	0.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	1	9	11.1%	100.0%	-88.9
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	34	0.0%	4.0%	-4.0

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	34	34	100.0%	96.0%	4.0
Aggressive outreach attempts were documented to confirm EPSDT status	0	0	CNC[1]	100.0%	CNC[1]
The Care Manager sent EPSDT reminders	0	0	CNC[1]	100.0%	CNC[1]
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	31	34	91.2%	92.0%	-0.8
Aggressive outreach attempts were documented to confirm immunization status	3	34	8.8%	50.0%	-41.2
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Dental needs are addressed for Enrollees aged 21 and above	34	34	100.0%	CNC[1]	CNC[1]
A dental visit occurred during the review period for Enrollees aged 1 to 21	16	34	47.1%	60.0%	-12.9
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	18	18	100.0%	100.0%	0.0
Dental reminders were sent to Enrollees aged 1 to 21	18	18	100.0%	100.0%	0.0
Enrollees aged 9 months to 26 months were tested twice for lead	3	26	11.5%	0.0%	11.5
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	13	7.7%	0.0%	7.7
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	23	23	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	23	23	100.0%	100.0%	0.0

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	34	34	100.0%	100.0%	0.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	34	34	100.0%	92.0%	8.0
A level of Care Management was determined for the Enrollee	34	34	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	34	34	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	34	34	100.0%	96.0%	4.0
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	1	1	100.0%	CNC[1]	CNC[1]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	2	2	100.0%	100.0%	0.0

**Not Included in aggregate score calculation.*

[1] Could not calculate.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	34	34	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	34	34	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	34	34	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	2	2	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Limitations

Audit results for the DDD and DCP&P Population should be considered cautiously due to the low sample size of 22 and 66 respectively.

Conclusions

Overall, UHCCP scored 85% and above in the following review categories (**Table 2**):

- Outreach (DDD Population) (100%)
- Coordination of Services (DDD Population) (100%)
- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (100%)
- Coordination of Services (DCP&P Population) (100%)

Overall, UHCCP scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (81%)
- Outreach (General Population) (83%)
- Preventive Services (General Population) (42%)
- Continuity of Care (General Population) (65%)
- Coordination of Services (General Population) (78%)
- Preventive Services (DDD Population) (73%)
- Continuity of Care (DDD Population) (83%)
- Preventive Services (DCP&P Population) (70%)

Care Management

Assessment Methodology

The Care Management Annual Assessment review consisted of pre-audit review of documentation provided by UnitedHealthcare Community Plan (UHCCP), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key UHCCP staff via WebEx were held on May 25, 2022, and post-audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on February 10, 2022 and received documentation from the MCOs on February 25, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on February 28, 2022. The audit review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2021 to December 31, 2021.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met in Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions. UHCCP received an overall compliance score of 73% in 2022. In 2021, the MCO received a score of 87%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM13, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2022. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s).

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	X	X	-	X	-	-	-	X
CM3	X	X	-	X	-	-	-	X
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	-	X	-	X	-	X	-	-
CM7	-	X	-	X	-	X	-	-
CM8	-	X	-	X	-	X	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	X	X	X	-	-	-	-	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	-	X	-	-	-	X
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-		-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	-	X	-	-	-	X
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	--	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	--	-
CM24	X	X	X	-	-	-	--	-
CM25	X	X	X	-	-	-	--	-
CM26	X	X	X	-	-	-	--	-
CM27	X	X	X	-	-	-	--	-
CM37	X	X	X	-	-	-	--	
TOTAL	**26**	**30**	**22**	**8**	**0**	**4**	**0**	**4**
Compliance Percentage			**73%**					

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored:** 84.6% For Enrollees hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored:** 81.3 % - Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020). During the Annual Care Management interviews on 5/25/2022, UHCCP was requested to provide additional documentation to support their prior documentation (Policies and/or Processes addressing Ongoing and Aggressive Outreach). IPRO informed UHCCP the documentation should be provided by end of business on 5/26/2022. The additional documentation was received from UHCCP on 6/6/2022.
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee	During the Annual Care Management interviews on 5/25/2022, UHCCP was requested to provide additional documentation (IHS Tracking Report) to support their prior documentation. IPRO informed UHCCP the documentation should be provided by end of business on

Element	Contract Language	Reviewer Comments
	designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	5/26/2022. The additional documentation was received from UHCCP on 6/6/2022.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored**: 34.3% -Comprehensive Needs Assessment was completed for the Enrollee. 72.2% - Initial outreach to complete a CNA. 75.0% - A level of Care Management was determined for the Enrollee. **In the 2022 Core CM file audit, UHCCP's DDD Enrollees scored:** 66.7% - Comprehensive Needs Assessment (CNA) was done and includes all required elements. 54.5% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). **In the 2022 Core CM file audit, UHCCP's DCP&P Enrollees scored:** 11.1% - When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment. During the Annual Care Management interviews on 5/25/2022, UHCCP was requested to provide additional documentation (CNA Tracking Report) to support their prior documentation. IPRO informed UHCCP the documentation should be provided by end of business on 5/26/2022. The additional documentation was received from UHCCP on 6/6/2022.

Element	Contract Language	Reviewer Comments
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored:** 78.3% - The Care Plan was developed within 30 days of CNA Completion.
CM13	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	During the Annual Care Management interviews on 5/25/2022, UHCCP was requested to provide additional documentation (CM Referral Report) to support their prior documentation. IPRO informed UHCCP the documentation should be provided by end of business on 5/26/2022. The additional documentation was received from UHCCP on 6/6/2022**.**
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored:** 50.0% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 30.8% - Aggressive outreach attempts were documented to confirm immunization status. 30.2% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 45.2% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above.

Element	Contract Language	Reviewer Comments
		34.9% - Dental needs are addressed for Enrollees aged 21 and above. 34.6% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 47.1% - Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21. 47.1% - Dental reminders were sent to Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 11.1% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. 57.1% - Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months. 50.0% - Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. **In the 2022 Core CM file audit, UHCCP's DDD Population Enrollees scored:** 80.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status confirmed by a reliable source. 0.0% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status confirmed by a reliable source. 18.8% - Appropriate vaccines have been administered for Enrollees aged 18 and above. **In the 2022 Core CM file audit, UHCCP's DCP&P Enrollees scored:** 8.8% - Aggressive outreach attempts were documented to confirm immunization status.

Element	Contract Language	Reviewer Comments
		47.1% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 11.5% - Enrollees aged 9 months to 26 months were tested twice for lead. 7.7% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2022 Core CM file audit, UHCCP's General Population Enrollees scored:** 60.7% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

Recommendations

For the General Population

1. **CM2:** UHCCP should ensure that adequate discharge planning is performed for Enrollees who are hospitalized.
2. **CM3:** UHCCP should ensure that Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020).
3. **CM3:** UHCCP should ensure that requested Policies and Procedures are submitted in a timely manner.
4. **CM6:** UHCCP should ensure that requested documents and documentations are submitted in a timely manner.
5. **CM7:** UHCCP should ensure that initial outreaches to complete a CNA is done and that a level of Care Management is determined for the Enrollee.
6. **CM8:** UHCCP should ensure that the Care Plan is developed within 30 days of CNA Completion.
7. **CM13**: UHCCP should ensure that requested documentation is submitted in a timely manner.
8. **CM14:** UHCCP shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, immunization status is confirmed by a reliable source and aggressive outreach attempts were documented to confirm immunization status.
9. **CM14:** UHCCP shall ensure that appropriate vaccines have been administered for Enrollees aged 18 and above and that aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above.
10. **CM14:** UHCCP shall ensure that dental needs are addressed for Enrollees aged 21 and above and ensure that attempts are made to obtain dental status for Enrollees aged 1 to 21.
11. **CM14:** UHCCP shall ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21 and ensure that dental reminders were sent to Enrollees aged 1 to 21.
12. **CM14:** UHCCP shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead.

13. **CM14:** UHCCP shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
14. **CM14:** UHCCP shall ensure that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months and ensure that the Care Manager makes attempts to obtain lead status for Enrollees aged 9 months to 72 months.
15. **CM19:** UHCCP shall ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

For the DDD Population:

1. **CM7:** UHCCP should ensure that a CNA is completed with all required components timely within 45 days of enrollment.
2. **CM13:** UHCCP should ensure that requested documents and documentations are submitted in a timely manner.
3. **CM14:** UHCCP shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
4. **CM14:** UHCCP shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
5. **CM14:** UHCCP shall ensure that appropriate vaccines have been administered for Enrollees aged 18 and above.

For the DCP&P Population

1. **CM7:** UHCCP should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and are completed within 45 days of the Enrollee's enrollment.
2. **CM7:** UHCCP should ensure that requested documents and documentations are submitted in a timely manner.
3. **CM13:** UHCCP should ensure that requested documents and documentations are submitted in a timely manner.
4. **CM14:** UHCCP shall ensure that aggressive outreach attempts were documented to confirm immunization status.
5. **CM14:** UHCCP shall ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21.
6. **CM14:** UHCCP shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
7. **CM14:** UHCCP shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
United Healthcare Community Plan of New Jersey

Review Period August 15, 2021 – June 30, 2022

April 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management Activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2021 and January 2022. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 110 cases for United Healthcare Community Plan of New Jersey (UHCCP), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 10/25/2021. Of the 200 cases in the initial Group E sample, 50 were identified by the MCO as high-risk. An additional 4 Group E cases were drawn from the MCO's report to the State of high risk cases, for a final sample of 54 for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 110 cases selected for the MCO, 102 Member files were reviewed and 100 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	27
Group D	Current Members Newly Enrolled to MLTSS	25
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	50
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	2

Population-Specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 40.9% to 83.1% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	August 2021 – June 2022			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		57.1%		57.1%
Member Outreach	36.0%	68.0%		52.0%
Telephonic Monitoring or Face-to-Face Visits	59.4%	73.0%	72.2%	69.2%
Initial Plan of Care (Including Back-up Plans)	47.2%	64.7%	58.1%	57.5%
Ongoing Care Management	36.4%	52.7%	35.4%	40.9%
Gaps in Care/Critical Incidents	68.0%	84.3%	90.0%	83.1%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 27 files were reviewed for new Members enrolled in managed care and newly eligible for MLTSS (Group C) and 2 files were excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 25 files were further reviewed for compliance in five (5) categories.

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	9	25	36.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	21	25	84.0%
Options Counseling was provided to the Member.	7	25	28.0%
Member was offered the participant direction option.[1]	16	20	80.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	5	6	83.3%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	11	25	44.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	5	25	20.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	21	25	84.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	4	20	20.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	18	18	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	7	18	38.9%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	4	20	20.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	4	4	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	15	20	75.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	2	5	40.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	5	25	20.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	17	20	85.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	4	25	16.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	25	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	15	25	60.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	0	4	0.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	16	25	64.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	18	25	72.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 25 files were further reviewed for compliance in all six (6) categories.

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	24	25	96.0%

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Screening for Community Services Assessment was submitted to DoAS by the 10th of the following month.	4	24	16.7%

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	17	25	68.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	24	25	96.0%
Options Counseling was provided to the Member.	18	25	72.0%
Member was offered the participant direction option.[1]	8	23	34.8%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	2	50.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	22	25	88.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	17	25	68.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	3	23	13.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	3	3	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	23	23	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	18	23	78.3%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	12	23	52.2%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	12	12	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	21	23	91.3%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	3	19	15.8%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	8	25	32.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	23	23	100.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	4	25	16.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	25	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	22	25	88.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	9	12	75.0%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	1	2	50.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	21	25	84.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	1	0.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	22	25	88.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 50 files were reviewed for the Members enrolled in managed care and MLTSS prior to the review period (Group E). Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Member Outreach is not assessed for Members in Group E. All 50 files were reviewed for compliance in four (4) categories.

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	50	50	100.0%
Options Counseling was provided to the Member.	15	50	30.0%
Member was offered the participant direction option.[1]	31	49	63.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	1	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	50	50	100.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	5	20.0%

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the Member's anniversary (from the date of the Initial Plan of Care).	N/A[1]	N/A[1]	N/A[1]
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	2	2	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1-Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	15	50	30.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	0	49	0.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	0	0	N/A
Care Manager completed an Annual Risk Assessment for the Member (not applicable for Members residing in CARS.	33	49	67.3%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.[2]	49	49	100.0%

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	33	0.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	2	50	4.0%

[1]Due to the nature of the audit and the timeframe, this was not included in the current audit

[2] The numerator represents the Members that were identified by IPRO as having a potential risk that the Care Manager also identified

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	10	50	20.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	50	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	40	50	80.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	0	0	N/A
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	5	7	71.4%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	1	1	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	50	98.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	41	50	82.0%

4. Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #9a (Member's Plan of Care is amended based on change of Member condition), #10 (Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment), #11 (Plans of Care developed using "Person-

Centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2021-2022 audit findings. Overall, the MCO's audit results ranged from 17.4% to 81% across all groups for five (5) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: UHCCP

Performance Measure	Group[1]	August 2021 - June 2022		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C			
	Group D			
	Group E			
	Ancillary Group C			
	Ancillary Group D			
	Total			
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E			
	Total			
#9a. Member's Plan of Care is amended based on change of Member condition[4]	Group C	0	0	N/A
	Group D	1	2	50.0%
	Group E	1	1	100.0%
	Total	2	3	66.7%
#10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment[5]	Group C	7	16	43.8%
	Group D	18	22	81.8%
	Group E			
	Total	25	38	65.8%
#11. Plans of Care developed using "Person-Centered principles"[6]	Group C	7	18	38.9%
	Group D	18	23	78.3%
	Group E	15	50	30.0%
	Total	40	91	44.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	4	20	20.0%
	Group D	12	23	52.2%
	Group E	0	49	0.0%
	Total	16	92	17.4%
#16. Member training on identifying/reporting critical incidents	Group C	18	25	72.0%
	Group D	22	25	88.0%
	Group E	41	50	82.0%
	Total	81	100	81.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period

[2] This measure was not calculated during this review

[3] This measure was not calculated during this review

[4] Members who did not have a documented change in condition during the study period are excluded from this measure

[5] Group E members are excluded from this measure

[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC

[7]Members in CARS are excluded from this measure

N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 57.1% in the Assessment category.

Group	8/21 to 6/22
Group C	
Group D	57.1%
Group E	
Combined	57.1%

Opportunities for Improvement for elements of the *Assessment* category include the following:

- Group D: United Healthcare should ensure the Screening for Community Services Assessment is submitted timely, by the 10th of the month following completion of the Screening for Community Services Assessment.

Member Outreach

Across groups, the MCO had a combined score of 52.0% in the Member Outreach category.

Group	8/21 to 6/22
Group C	36.0%
Group D	68.0%
Group E[1]	
Combined	52.0%

[1]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for the elements of *Member Outreach* category include the following:

- Group C: United Healthcare should ensure that the Care Manager contacts the Member within five (5) business days of MLTSS enrollment to schedule a telephonic visit to develop the Member's Plan of Care.

- Group D: United Healthcare should ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services Assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring or Face-to-Face Visits

Across all three groups, the MCO had a combined score of 69.2% in the Telephonic Monitoring Visits category.

Group	8/21 to 6/22
Group C	59.4%
Group D	73.0%
Group E	72.2%
Combined	69.2%

Opportunities for Improvement for elements of the *Telephonic Monitoring or Face-to-Face Visits* category include the following:

- Group C: United Healthcare should ensure that the Member (or Member's Representative) are present for, and included in, all telephonic meetings or face-to-face visits with the Care Manager. United Healthcare should ensure Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion. The Plan should ensure that a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold be documented as a numeric percentage.

- Group D: United Healthcare should ensure Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion.

- Group E: United Healthcare should ensure Options Counseling is provided to all MLTSS Members, and the MLTSS Care Manager should discuss and offer Participant Direction as applicable during Options Counseling. The Plan should ensure that a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold should be documented as a numeric percentage.

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 57.5% in the Initial Plan of Care (Including Back-up Plans) category.

Group	8/21 to 6/22
Group C	47.2%
Group D	64.7%
Group E	58.1%
Combined	57.5%

Opportunities for Improvement for elements of the *Initial Plan of Care (Including Back-up Plans)* category include the following:

- Group C: United Healthcare should ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member representative, and a copy of the Plan of Care should be provided to the Member within 45 days of enrollment in the MLTSS program. United Healthcare should ensure that the Member file contains documentation of coordination with the Member's primary care physician (PCP) in developing the Plan of Care. United Healthcare should ensure that the Member is assessed for PCA services within 45 days of enrollment into MLTSS. United Healthcare should ensure that the Plan of Care reflects a

Member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. United Healthcare should confirm that the State mandated Back-up Plan is completed, signed/verbally acknowledged, and dated by the Member/Member Representative. United Healthcare should ensure, Care Managers complete an Annual Risk Assessments for MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member. United Healthcare should ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Members understand their Rights and Responsibilities.

- Group D: United Healthcare should ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member Representative, and a copy of the Plan of Care should be provided to the Member within 45 days of MLTSS enrollment. United Healthcare should ensure the Care Manager assesses the Member for PCA as cable within 45 days of MLTSS enrollment. United Healthcare should ensure that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. United Healthcare should confirm that the State mandated Back-up Plan is completed, signed/verbally acknowledged, and dated by the Member/Member Representative. United Healthcare should ensure that Members who were identified as having a positive risk, had a Risk Management Agreement with al its components completed, signed/verbally acknowledged, and dated by the Member. United Healthcare should ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Members understand their Rights and Responsibilities.

- Group E: United Healthcare should ensure that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative should be present and involved in the development and modification of agreed upon goals. The Member should be given the opportunity to express their needs and preferences, and their needs and preferences should be acknowledged and addressed in the Plan of Care. United Healthcare should confirm that the State mandated Back-up Plan is completed, signed/verbally acknowledged, and dated by the Member/Member Representative. United Healthcare should ensure the Care Manager complete an Annual Risk Assessments for the MLTSS Members, and if a risk is identified a Risk Management Agreement should be completed, signed/verbally acknowledged, and dated by the Member. United Healthcare should ensure Members receive their Rights and Responsibilities in writing during the review period, Rights and Responsibilities should be discussed, and the Care Manager should confirm the Members understand their Rights and Responsibilities.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 40.9% in the Ongoing Care Management category.

Group	8/21 to 6/22
Group C	36.4%
Group D	52.7%
Group E	35.4%
Combined	40.9%

Opportunities for Improvement for elements of the *Ongoing Care Management* category include the following:

- Group C: United Healthcare should ensure the Member has services in place within 45 calendar days of enrollment into MLTSS. United Healthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. United Healthcare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. United Healthcare should ensure that the Member's Plan of Care was updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signed/verbally acknowledged and is provided with a copy of the Plan of Care. United Healthcare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.

- Group D: United Healthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. United Healthcare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Members residing in the Community. United Healthcare should ensure that the Member's Plan of Care was updated and/or reviewed with a significant change, the Member agrees with the Plan of Care, and that the Member signed/verbally acknowledged and is provided with a copy of the Plan of Care. United Healthcare should ensure that Members with a significant change in Member condition has documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.

- Group E: United Healthcare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the community, and at least every 180 days for Members in CARS. United Healthcare should ensure that the Member's Plan of Care was updated and/or reviewed with a significant change, the Member agrees with the Plan of Care, and that the Member signed/verbally acknowledged and is provided with a copy of the Plan of Care. United Healthcare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. United Healthcare should ensure that the Care Managers complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 83.1% in the Gaps in Care/Critical Incidents category.

Group	8/21 to 6/22
Group C	68.0%
Group D	84.3%
Group E	90.0%
Combined	83.1%

Opportunities for Improvement for elements of the *Gaps in Care/Critical Incidents* category include the following:

- Group C: United Healthcare should ensure the Care Manager reviews the process for immediately reporting gaps in service delivery with the Members receiving MLTSS services and not residing in community alternative

residential settings (CARS). United Healthcare should ensure there is documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.

- Group D: United Healthcare should ensure the Care Manager reviews the process for immediately reporting gaps in service delivery with the Members receiving MLTSS services (excluding Members residing in CARS), and for those Members who have a reported gap in service there is documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.

Performance Measures

Overall, the MCO scored below 86% in all five (5) performance measures.

- PM #9a: Member's Plan of Care is amended based on change of Member condition
- PM #10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment
- PM #11: Plans of Care developed using "Person-Centered principles"
- PM #12: MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan
- PM #16: Member training on identifying/reporting Critical Incidents

Opportunities for Improvement for Performance Measures include the following:

- Group D: PM #9a: United Healthcare should ensure the Member's Plan of Care is amended based on change of Member needs or condition. The Plan of Care should be reviewed, signed, and dated by the Member and/or authorized representative.

- Group C/Group D: PM #10. United Healthcare should ensure that the Plans of Care aligns with Member's needs based on the results of the NJ Choice Assessment.

- Group C/Group D/Group E: PM #11: United Healthcare should ensure that the Care Manager develops the Member's Plan of Care using "Person-Centered principles."

- Group C/Group D/Group E PM #12: United Healthcare should ensure that the MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan signed by the Member/Member's authorized representative.

- Group C/Group E: PM #16: United Healthcare should ensure that the Member's file contains documentation of Member training on identifying/reporting critical incidents.

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

UnitedHealthcare Community Plan
Managed Long Term Services and Supports (MLTSS)
2022 Annual Assessment Review of
Care Management

Review Period - July 1, 2021 to June 30, 2022

January 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction……4

Care Management and Continuity of Care……6

List of Tables

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management……5

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care……6

Table 1b: Findings for Resolved MLTSS Care Management and Continuity of Care Elements ……6-8

Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standards under review; interviews with key UHCCP staff (held via WebEx on January 10, 2023) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on October 21, 2022 and received from the MCOs on November 4, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on November 7, 2022. The offsite review team was made up of Cynthia Steffe and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2021 to June 30, 2022. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2022 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. UHCCP received an overall compliance score of 100% in 2022. In 2021, the MCO received a score of 70% for this category. **Table 1a** presents an overview of the results, and **Table 1b** presents Contract language for resolved element(s).

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	-	X	X		-	-	X	-
CM32	X	X	X	-	-	-	-	-
CM34	-	X	X		-	-	X	-
CM36	X	X	X	-	-	-	-	-
CM37	-	X	X		-	-	X	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**7**	**10**	**10**	**0**	**0**	**0**	**3**	**0**
Compliance Percentage			**100%**					

Table 1b: Findings for Resolved MLTSS Care Management and Continuity of Care Elements

Element	Contract Language
CM31	9.5.2.A 9.5.2. B 9.5.2. A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members. 2. Caseload management and casework practices. 3. Human services principles for determining eligibility for benefits and services. 4. Ability to effectively solve problems and locate community resources; and

Element	Contract Language
	5. The needs and service delivery system for all populations in the Care Manager's caseload.
CM34	9.5.5. J 9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).
CM37	4.7.4. A 4.7.4. A INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and, in the time, frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
UnitedHealthcare Community Plan of New Jersey

February 2023

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30th. Due to COVID-19, the prior review period was from July 1, 2019 through February 29th, 2020. An extension period was included through March 1, 2020 through December 31st, 2020 to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was Janaury 1, 2021 through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 through August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020 where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF/SCNF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for UnitedHealthcare Community Plan of New Jersey (UHCCP), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on August 14, 2021, and
- The member must have been enrolled as a NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on August 14, 2021, and
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (August 14, 2021).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021 with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months, and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for UHCCP, 102 member files were reviewed and included in the results pertaining to the Plan of Care for Institutional Settings. Two (2) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" (not applicable) were not included in scoring. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting (see **Tables 2a-e**). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (January 1, 2021-August 14, 2021)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	21	100	21.0%
Documented Review of the Facility Plan of Care by the Care Manager	20	21	95.2%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	19	21	90.5%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature**) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS)	0	5	0.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	77	100	77.0%
Care Manager arranged Plan of Care services using both formal and informal supports	77	100	77.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	77	100	77.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	77	100	77.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	76	100	76.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	1	0.0%

Table 2c.

Transition Planning	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	79	100	79.0%
Evidence of the **Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	3	100	3.0%
Member was present at each telephonic visit or was involved from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in a telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	85	100	85.0%
Timely Telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	80	100	80.0%
Members requiring coordination of care had coordination of care by the Care Manager	91	100	91.0%
Care Manager explained and discussed any payment liability with the Member if a member had any payment liability for the NF/SCNF admission	66	100	66.0%

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	76	100	76.0%
Care Manager reviewed the Member's Rights and Responsibilities	78	100	78.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	78	100	78.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	76	100	76.0%

CNC: Could not calculate

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period	N/A		
Member was admitted to an NF/SCNF during the review period	N/A		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	N/A	N/A	N/A

N/A: Not Applicable (PASRR questions were removed this year; Due to the COVID-19 pandemic, face-to-face visits were placed on hold)

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for UHCCP, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 3 and Table 4, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

NF/SCNF Members Transitioned to HCBS	Review Period (January 1, 2021- August 14, 2021)		
	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC

CNC: Could not calculate

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF/SCNF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: UHCCP

Performance Measure	Group	January 2021 – August 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	0	5	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	5	0.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	78	100	78.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	78	100	78.0%
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	1	0.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	1	0.0%
#11. Plans of Care developed using "person-centered principles"[4]	Group 1	77	100	77.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	77	100	77.0%
#16. Member training on identifying/reporting critical incidents	Group 1	76	100	76.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	76	100	76.0%

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

Limitations

The annual NF/SCNF CM Audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. During the 2021 NF/SCNF CM Audit the MCOs were only evaluated based on scores from the review period (period through which they could conduct normal business activities) not the expansion period. The 2021 NF CM review period changed from a full year review to a partial year review beginning January 1, 2021 and ending August 14, 2021.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (95.2%)
- MLTSS Plan of Care on file (90.5%)
- Members requiring coordination of care had coordination of care (91.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (21.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (0.0%)
- Care Managers used a person-centered approach (77.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (77.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (77.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (77.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (76.0%)
- Updated Plan of Care for a Significant Change (0.0%)
- Member was identified for transfer to HCBS and was offered options (79.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (3.0%)
- Member was present at each telephonic visit (85%)
- Timely Telephonic Review of Member Placement and Services (80%)
- Care Manager explained and discussed any payment liability (66.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (76.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (78.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (78.0%)
- Member and/or representative had training on how to report a critical incident (76.0%)

Recommendations for audit elements include the following:

UHCCP's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The Care Manager should use a person-centered approach while using both formal and informal supports. Member's Plan of Care should have developed goals that address the issues that are identified during the assessment and contain goals that met all criteria. UHCCP should ensure that documentation of the Member's agreement/disagreement with the Plan of Care statements were

documented, and Member was identified for transfer to HCBS and was offered options. Plan of Care process is reviewed, revised if applicable for any significant changes. The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. UHCCP should ensure timely telephonic review of member placement and services and the MLTSS Care Managers is to discuss payment liability. UHCCP should ensure that the Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. The Care Manager reviews the Member's Rights and Responsibilities, educates the Member on how to file a grievance and/or an appeal and member and/or representative has training on how to report a critical incident.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (0.0%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (78.0%)
- #9a. Member's Plan of Care is amended based on change of member condition (0.0%)
- #11. Plans of Care developed using "person-centered principles" (77.0%)
- #16. Member training on identifying/reporting critical incidents (76.0%)

Recommendations for MLTSS Performance Measures include the following:

UHCCP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS and should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary. The UHCCP MLTSS Care managers should use "person-centered principles" when developing their Plans of Care. UHCCP MLTSS Care managers should ensure that member training on identifying/reporting critical incidents is being completed.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix F: WCHP 2022 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
WellCare Health Plans of NJ
Review Period: January 1, 2021 – December 31, 2021

December 2022

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction 4

Methodology 4

Pre-Audit Activities 4

Audit Activities 6

Audit Results 6

GP Population Findings 6

DDD Population Findings 11

DCP&P Population Findings 13

Conclusions 15

Care Management Annual Assessment 16

Care Management 16

Recommendations 22

List of Tables

Table 1: Sampling Methodology 5
Table 2: Aggregate Results by Category 6
Table 3: Identification – GP Population 6
Table 4: Outreach – GP Population 7
Table 5: Preventive Services – GP Population 8
Table 6: Continuity of Care – GP Population 8
Table 7: Coordination of Services – GP Population 9
Table 8: Outreach – DDD Population 11
Table 9: Preventive Service – DDD Population 11
Table 10: Continuity of Care – DDD Population 12
Table 11: Coordination of Services – DDD Population 12
Table 12: Outreach – DCP&P Population 13
Table 13: Preventive Services – DCP&P Population 13
Table 14: Continuity of Care – DCP&P Population 14
Table 15: Coordination of Services – DCP&P Population 14
Table 16: Rating Scale for the Annual Care Management Assessment 16
Table 17: Summary of Findings for Care Management Annual Assessment 17
Table 18: Findings for Deficient Care Management Elements 18

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report for the DDD and DCP&P Populations, Contract references, NJ Care Management Workbook and CDC Immunization Schedules. In 2020, IPRO, OQA, and DMAHS collaborated on revising the NJ EQRO MCO Care Management Audit Tool for the General Population (GP) to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology as shown in Table 1 resulted in the selection of 164 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), including a 10% oversample for the GP.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

Random samples of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) were selected. All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (30). All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (24).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599, 49499 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2021	>= 3 months as of 12/31/2021	>= 3 months and < 18 years as of 12/31/2021
Sex	Both	Both	Both
Enrollment in HMO	Enrolled at any time during 6-month period from 1/1/2021 to 7/1/2021	Initial enrollment between 1/1/2021 and 12/31/2021	Initial enrollment between 1/1/2021 and 12/31/2021
Current Enrollment	Enrolled as of 12/31/2021	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO from initial enrollment through 12/31/2021 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2021 allowing one gap <= 45 days. Where Enrollee meets enrollment criteria for 2 MCOs in 2021, the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.

- File listings identifying the files that needed to be submitted to IPRO as well as instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WCHP's 2021 audit results ranged from 35% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP 2021 (n=100)	GP 2020 (n=100)	PPD[2]	DDD 2021 (n=23)	DDD 2020 (n=34)	PPD[2]	DCP&P 2021 (n=17)	DCP&P 2020 (n=21)	PPD[2]
Identification[1]	80%	89%	-8						
Outreach	82%	97%	-15	96%	97%	-1	82%	100%	-18
Preventive Services	35%	90%	-55	69%	46%	23	73%	76%	-2
Continuity of Care	73%	96%	-23	90%	91%	-1	91%	96%	-5
Coordination of Services	78%	100%	-22	94%	98%	-4	100%	100%	0

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

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

GP Population Findings

A total of 102 files were reviewed for the GP Population. Of the 102 files reviewed, 2 files were excluded, 18 Enrollees were new Enrollees, and 82 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only)	6	8	75.0%	50.0%	25.0
When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's	2	5	40.0%	0.0%	40.0

Identification	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
enrollment (applies to new Enrollees only)					
Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) *	12	15	80.0%	71.4%	8.6
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to new Enrollees only)	0	3	100.0%[1]	92.9%[1]	7.1
Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020) *	12	82	14.6%	2.3%	12.3
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020)	12	70	82.9%[1]	92.9%[1]	-10.0
Enrollees identified by the Plan as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management) *	52	58	89.7%	79.8%	9.9

**Not Included in aggregate score calculation*

[1] Percentage rate is indicative of an inverse percentage.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Outreach

This section applies only to Enrollees with identified Care Management needs not already in Care Management (82).

Table 4: Outreach – GP Population

Outreach	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	58	82	70.7%	98.7%	-28.0
The outreach for CNA was timely within 30 days of the identification of CM needs	57	58	98.3%	94.7%	3.5
Outreach was successful (even if the Enrollee declines to complete the CNA) *	35	58	60.3%	65.8%	-5.4
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	20	23	87.0%	96.9%	-9.9
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	19	35	54.3%	30.0%	24.3
The Enrollee declined Care Management*	20	58	34.5%	21.1%	13.4

**Not Included in aggregate score calculation*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

This section includes Enrollees with identified Care Management needs, those of which accepted Care Management, or who were already in Care Management (80).

Table 5: Preventive Services – GP Population

Preventive Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	0	5	0.0%	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm EPSDT status	3	5	60.0%	CNC[1]	CNC[1]
The Care Manager sent EPSDT reminders	2	5	40.0%	CNC[1]	CNC[1]
The Enrollee's immunizations are up to date for Enrollees age 0-18 and immunization status is confirmed by a reliable source	0	5	0.0%	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status	4	5	80.0%	CNC[1]	CNC[1]
Appropriate vaccines have been administered for Enrollees aged 18 and above	10	75	13.3%	94.1%	-80.8
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	34	64	53.1%	0.0%	53.1
Dental needs are addressed for Enrollees aged 21 and above	26	70	37.1%	91.2%	-54.1
A dental visit occurred during the review period for Enrollees aged 1 to 21	1	5	20.0%	CNC[1]	CNC[1]
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	4	4	100.0%	CNC[1]	CNC[1]
Dental reminders were sent to Enrollees aged 1 to 21	2	4	50.0%	CNC[1]	CNC[1]
Enrollees aged 9 months to 26 months were tested twice for lead	0	3	0.0%	CNC[1]	CNC[1]
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	0	3	0.0%	CNC[1]	CNC[1]
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	3	3	100.0%	CNC[1]	CNC[1]
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	2	3	66.7%	CNC[1]	CNC[1]

[1] Could not calculate

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

This section includes Enrollees with identified Care Management needs who accept Care Management, or who were already in Care Management (74). If Enrollees decline Care Management afterwards, they will be removed from this section.

Table 6: Continuity of Care – GP Population

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
A Comprehensive Needs Assessment was completed for the Enrollee	26	74	35.1%	88.2%	-53.1
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater, or identification of potential Care Management needs through other sources.) (Applies to new Enrollees, and	15	26	57.7%	93.1%	-35.4

Continuity of Care	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
existing Enrollees not already enrolled in Care Management.)[1]					
A level of Care Management was determined for the Enrollee	25	26	96.2%	100.0%	-3.8
The Enrollee is in Community Based Care Management (CBCM)*	0	80	0.0%	64.7%	-64.7
A Care Plan was completed for the Enrollee that included all required components	27	27	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	26	26	100.0%	93.8%	6.2
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	27	27	100.0%	96.7%	3.3
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	3	3	100.0%	100.0%	0.0

**Not Included in aggregate score calculation*

[1] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

This section includes Enrollees with identified Care Management needs who accepted Care Management, or who were already in Care Management (80).

Table 7: Coordination of Services – GP Population

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	57	80	71.3%	100.0%	-28.8
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	28	28	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider	22	22	100.0%	100.0%	0.0

Coordination of Services	General Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
services, utilization management) as appropriate for the Enrollee					
For Enrollees who were hospitalized, adequate discharge planning was performed	40	58	69.0%	100.0%	-31.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DDD Population Findings

A total of 24 files were reviewed for the DDD Population with 1 exclusion.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	22	23	95.7%	97.1%	-1.4
The outreach for CNA was timely within 45 days of enrollment	21	22	95.5%	97.0%	-1.5
Outreach was successful (even if the Enrollee declines to complete the CNA) *	18	22	81.8%	69.7%	12.1
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	17	18	94.4%	93.3%	1.1
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	4	18	22.2%	8.7%	13.5
The Enrollee declined Care Management*	4	22	18.2%	6.1%	12.1

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 9: Preventive Service – DDD Population

Preventive Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	5	9	55.6%	38.5%	17.1
Aggressive outreach attempts were documented to confirm EPSDT status	4	4	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	4	4	100.0%	87.5%	12.5
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	2	6	33.3%	28.6%	4.8
Aggressive outreach attempts were documented to confirm immunization status	5	6	83.3%	100.0%	-16.7
Appropriate vaccines have been administered for Enrollees aged 18 and above	1	17	5.9%	11.1%	-5.2
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	14	16	87.5%	54.2%	33.3
Dental needs are addressed for Enrollees aged 21 and above	22	23	95.7%	14.3%	81.4
A dental visit occurred during the review period for Enrollees aged 1 to 21	4	6	66.7%	7.7%	59.0
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	2	2	100.0%	91.7%	8.3
Dental reminders were sent to Enrollees aged 1 to 21	2	2	100.0%	91.7%	8.3
Enrollees aged 9 months to 26 months were tested twice for lead	0	1	0.0%	0.0%	0.0
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	1	1	100.0%	0.0%	100.0
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	1	1	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	1	1	100.0%	100.0%	0.0

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	18	19	94.7%	79.4%	15.3
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	17	20	85.0%	96.3%	-11.3
A level of Care Management was determined for the Enrollee	14	18	77.8%	100.0%	-22.2
The Enrollee is in Community Based Care Management (CBCM)*	8	19	42.1%	2.9%	39.2
A Care Plan was completed for the Enrollee that included all required components	14	14	100.0%	87.9%	12.1
The Care Plan was developed within 30 days of CNA Completion	18	18	100.0%	87.9%	12.1
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[1]	0.0%	CNC[1]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC[1]	CNC[1]

**Not Included in aggregate score calculation*

[1] Could not calculate

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	17	19	89.5%	100.0%	-10.5
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	14	14	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	14	14	100.0%	93.5%	6.5
For Enrollees who were hospitalized, adequate discharge planning was performed	0	1	0.0%	100.0%	-100.0
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2021 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	CNC[1]	100.0%	CNC[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	CNC[1]	CNC[1]	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

DCP&P Population Findings

A total of 30 files were reviewed for the DCP&P Population. (13) files were excluded from the DCP&P Population due to adoption and were not subject to further review in the following categories.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[1]
Initial outreach to complete a CNA was done	17	17	100.0%	100.0%	0.0
The outreach for CNA was timely within 45 days of enrollment	11	17	64.7%	100.0%	-35.3
Outreach was successful (even if the Enrollee declines to complete the CNA) *	17	17	100.0%	100.0%	0.0
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment	7	7	100.0%	85.7%	14.3
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	17	5.9%	0.0%	5.9

**Not Included in aggregate score calculation.*

[1] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Preventive Services

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source	5	17	29.4%	76.2%	-46.8
Aggressive outreach attempts were documented to confirm EPSDT status	12	12	100.0%	100.0%	0.0
The Care Manager sent EPSDT reminders	12	12	100.0%	100.0%	0.0
The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source	6	17	35.3%	66.7%	-31.4
Aggressive outreach attempts were documented to confirm immunization status	17	17	100.0%	100.0%	0.0
Appropriate vaccines have been administered for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above	0	0	CNC[1]	CNC[1]	CNC[1]
Dental needs are addressed for Enrollees aged 21 and above	17	17	100.0%	CNC[1]	CNC[1]
A dental visit occurred during the review period for Enrollees aged 1 to 21	7	15	46.7%	50.0%	-3.3
Care Manager made attempts to obtain dental status for Enrollees aged 1 to 21	7	8	87.5%	100.0%	-12.5
Dental reminders were sent to Enrollees aged 1 to 21	8	8	100.0%	100.0%	0.0
Enrollees aged 9 months to 26 months were tested twice for lead	0	3	0.0%	0.0%	0.0
Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test	2	3	66.7%	33.3%	33.3
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	3	3	100.0%	100.0%	0.0
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	3	3	100.0%	100.0%	0.0

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Continuity of Care

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[3]
Comprehensive Needs Assessment (CNA) was done and includes all required elements*	17	17	100.0%	100.0%	0.0
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) [2]	11	17	64.7%	81.0%	-16.2
A level of Care Management was determined for the Enrollee	17	17	100.0%	100.0%	0.0
A Care Plan was completed for the Enrollee that included all required components	17	17	100.0%	100.0%	0.0
The Care Plan was developed within 30 days of CNA Completion	17	17	100.0%	100.0%	0.0
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	CNC[1]	100.0%	CNC[1]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	CNC[1]	CNC[1]	CNC[1]

**Not Included in aggregate score calculation.*

[1] Could not calculate.

[2] The rate is calculated based on B2 timeliness of CNA outreach, D1 completeness of CNA, and D2 date of CNA.

[3] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Coordination of Services

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population				
	Numerator	Denominator	Percent (2021)	Percent (2020)	PPD[2]
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	17	17	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	17	17	100.0%	100.0%	0.0
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	17	17	100.0%	100.0%	0.0
For Enrollees who were hospitalized, adequate discharge planning was performed	0	0	CNC[1]	100.0%	CNC[1]

[1] Could not calculate.

[2] Rates reported for the current year and the prior year are founded to one decimal place. Slight variations in the PPD may be noted due to this.

Limitations

Audit results for the DDD and DCP&P Population should be considered cautiously due to the low sample size of 24 and 30 respectively.

Conclusions

Overall, WCHP scored 85% and above in the following review categories (**Table 2**):

- Outreach (DDD Population) (96%)
- Continuity of Care (DDD Population) (90%)
- Coordination of Services (DDD Population) (94%)
- Continuity of Care (DCP&P Population) (91%)
- Coordination of Services (DCP&P Population) (100%)

Overall, WCHP scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (80%)
- Outreach (General Population) (82%)
- Preventive Services (General Population) (35%)
- Continuity of Care (General Population) (73%)
- Coordination of Services (General Population) (78%)
- Preventive Services (DDD Population) (69%)
- Outreach (DCP&P Population) (82%)
- Preventive Services (DCP&P Population) (73%)

Care Management

Assessment Methodology

The Care Management Annual Assessment review consisted of pre-audit review of documentation provided by WellCare Health Plans of New Jersey, Inc. (WCHP), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD and DCP&P Populations. Interviews with key WCHP staff via WebEx were held on May 23, 2022, and post-audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on February 10, 2022, and received documentation from the MCOs on February 25, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on February 28, 2022. The audit review team was made up of Tina Iervolino, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from January 1, 2021, to December 31, 2021.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met in Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions. WCHP received an overall compliance score of 80% in 2022. In 2021, the MCO received a score of 90%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM13, CM14, CM15, CM16, CM17 and CM19 was based on results from the Core Medicaid CM Audit conducted in 2022. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2021 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s).

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM1	X	X	X	-	-	-	-	-
CM2	X	X	-	X	-	-	-	X
CM3	X	X	-	X	-	-	-	X
CM4	X	X	X	-	-	-	-	-
CM5	X	X	X	-	-	-	-	-
CM6	-	X	-	X	-	X	-	-
CM7	-	X	-	X	-	X	-	-
CM8	X	X	X	-	-	-	-	-
CM9	X	X	X	-	-	-	-	-
CM10	X	X	X	-	-	-	-	-
CM11	X	X	X	-	-	-	-	-
CM12	X	X	X	-	-	-	-	-
CM13	X	X	X	-	-	-	-	-
CM14	-	X	-	X	-	X	-	-
CM15	X	X	X	-	-	-	-	-
CM16	X	X	X	-	-	-	-	-
CM17	X	X	X	-	-	-	-	-
CM18a	X	X	X	-	-	-	-	-
CM18c	X	X	X	-	-	-	-	-
CM18d	X	X	X	-	-	-	-	-
CM19	X	X	-	X	-	-	-	X
CM20	X	X	X	-	-	-	-	-
CM21	X	X	X	-	-	-	-	-
CM22	X	X	X	-	-	-	-	-

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM23	X	X	X	-	-	-	-	-
CM24	X	X	X	-	-	-	-	-
CM25	X	X	X	-	-	-	-	-
CM26	X	X	X	-	-	-	-	-
CM27	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
TOTAL	**27**	**30**	**24**	**6**	**0**	**3**	**0**	**3**
Compliance Percentage			**80%**					

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 69% - for Enrollees who were hospitalized, adequate discharge planning was performed. **In the 2022 CM file audit the Plan scored: for the DDD Population Enrollees:** 0.0% - for Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 82.9% - Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020). 80% - Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only). 14.6% - Enrollees Enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCOs must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 75% - IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only).

Element	Contract Language	Reviewer Comments
	who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	40% - When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only).
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 35.1% - A Comprehensive Needs Assessment was completed for the Enrollee. 70.7%- Initial outreach to complete a CNA was done. **In the 2022 CM file audit the Plan scored: for the DDD Population Enrollees:** 77.8% - A level of Care Management was determined for the Enrollee. **In the 2022 CM file audit the Plan scored: for the DCP&P Population Enrollees:** 64.7% - The outreach for the CNA was timely within 45 days of enrollment. 64.7% - The CNA was completed timely (within 45 days of the enrollees enrollment).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 0.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 60% - Aggressive outreach attempts were documented to confirm EPSDT status. 40% - The Care Manager sent EPSDT reminders.

Element	Contract Language	Reviewer Comments
		0.0% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 80% - Aggressive outreach attempts were documented to confirm immunization status. 13.3% - Appropriate vaccines have been administered for Enrollees aged 18 and above. 53.1% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above. 37.1% - Dental needs are addressed for Enrollees aged 21 and above. 20% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 50% - Dental reminders were sent to Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 0.0% - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. 66.7% - Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. **In the 2022 CM file audit the Plan scored: for the DDD Population Enrollees:** 55.6% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 33.3% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.

Element	Contract Language	Reviewer Comments
		83.3% - Aggressive outreach attempts were documented to confirm immunization status. 5.9% Appropriate vaccines have been administered for Enrollees aged 18 and above. 66.7% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. **In the 2022 CM file audit the Plan scored: for the DCP&P Population Enrollees:** 29.4% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. 35.3% - The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. 46.7% - A dental visit occurred during the review period for Enrollees aged 1 to 21. 0.0% - Enrollees aged 9 months to 26 months were tested twice for lead. 66.7 % - Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2022 CM file audit the Plan scored: for the General Population Enrollees:** 71.3% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

Recommendations

For General Population:

1. **CM2:** WellCare should ensure for GP Enrollees who are hospitalized, that adequate discharge planning is performed.
2. **CM3:** WellCare should ensure that Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) and the Enrollees identified by the Plan as having potential Care Management needs (applies to new Enrollees only) as well as the Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2020).
3. **CM6:** WellCare should ensure that an IHS is completed within 45 days of enrollment for new General Population Enrollees and aggressive outreach should be attempted and documented when initial outreach is unsuccessful within 45 days of the Enrollee's enrollment (applies to new Enrollees only).
4. **CM7:** WellCare should ensure that initial outreach to complete a CNA is done timely. WellCare should ensure that the Comprehensive Needs Assessment should be completed for all applicable Enrollees.
5. **CM14:** WellCare should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm EPSDT status, and the Care Manager sent EPSDT reminders.
6. **CM14:** WellCare shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm immunization status.
7. **CM14:** WellCare shall ensure that those appropriate vaccines have been administered for Enrollees aged 18 and above and that aggressive outreach attempts were documented to confirm immunization status for Enrollees aged 18 and above.
8. **CM14:** WellCare shall ensure that dental needs are addressed for Enrollees aged 21 and above, that a dental visit occurred during the review period for Enrollees aged 1 to 21 and that dental reminders were sent to Enrollees aged 1 to 21.
9. **CM14:** WellCare shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
10. **CM14:** WellCare shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.
11. **CM14:** WellCare shall ensure that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months.
12. **CM19:** For the General Population: When appropriate for the applicable Enrollees, WellCare shall ensure that the Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)documentation of all contacts and linkages to medical and other services in are in the Enrollee's case files.

For the DDD Population:

1. **CM2:** WellCare should ensure for DDD Enrollees who are hospitalized, that adequate discharge planning is performed.
2. **CM7:** WellCare should ensure that a level of Care Management is determined for the Enrollee.
3. **CM14:** WellCare shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.

4. **CM14:** WellCare shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source and that aggressive outreach attempts are documented to confirm immunization status.
5. **CM14:** WellCare shall ensure that appropriate vaccines have been administered for Enrollees aged 18 and above.
6. **CM14:** WellCare shall ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21.
7. **CM14:** WellCare shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead.

For the DCP&P Population:

1. **CM7:** WellCare should ensure that the outreach for the CNA was timely within 45 days of the Enrollee's enrollment. Wellcare should ensure the completion of the CNA was timely within 45 days of enrollment.
2. **CM14:** WellCare shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
3. **CM14:** WellCare shall ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source.
4. **CM14:** WellCare shall ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21.
5. **CM14:** WellCare shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead.
6. **CM14:** WellCare shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
WellCare Health Plan of New Jersey, Inc.

Review Period August 15, 2021 – June 30, 2022

April 2023

Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to Fully Integrated Dual Eligible (FIDE) Members. Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 8/15/2021 through 6/30/2022.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2021 and January 2022. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management and Gaps in Care/Critical Incidents. The audit tool included State-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No) and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 110 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 8/15/2021 and 1/1/2022	• The Member must have been initially enrolled in MLTSS HCBS between 8/15/2021 and 1/1/2022. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2022 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Groups C and D, a random sample of 25 cases with an oversample of three cases was drawn. For Group E, an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its **Resumption of Face to Face Visits** report, submitted to the State on 9/1/2021. Of the 200 cases in the initial Group E sample, 49 were identified by the MCO as high-risk. An additional 5 Group E cases were drawn from the MCO's report to the State of high risk cases, for a final sample of 54 for Group E. In total, the sample selected across all three groups was 100 cases with an oversample of 10.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team. Paper and/or electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 110 cases selected for the MCO, 105 Member files were reviewed and 100 were included in the results:

Group	Description	Number of Files
Group C	Members New to Managed Care and Newly Eligible to MLTSS	26
Group D	Current Members Newly Enrolled to MLTSS	25
Group E	Members Enrolled in the MCO and MLTSS prior to the review period	54
Exclusions	Member excluded because of permanent NF placement or no authorization from the Office of Community Choice Options (OCCO) on file during the review period	5

Population-Specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

The MCO's audit results for the combined MLTSS sample ranged from 41.4% to 94.5% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	August 2021 - June 2022			
Determination by Category	Group C[1]	Group D	Group E[1,2]	Combined[3]
Assessment		43.2%		43.2%
Member Outreach	60.0%	80.0%		70.0%
Telephonic Monitoring or Face-to-Face Visits	89.7%	92.1%	85.0%	87.9%
Initial Plan of Care (Including Back-up Plans)	80.2%	86.4%	90.0%	86.9%
Ongoing Care Management	39.6%	50.0%	37.1%	41.4%
Gaps in Care/Critical Incidents	80.0%	100.0%	99.0%	94.5%

[1]Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category

[2]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

1. New Members to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 26 files were reviewed for new Members enrolled in managed care and newly eligible for MLTSS (Group C) and 1 file was excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group C were not evaluated for elements in the Assessment category. All 25 files were further reviewed for compliance in five (5) categories.

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.	15	25	60.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	24	25	96.0%
Options Counseling was provided to the Member.	24	25	96.0%
Member was offered the participant direction option.[1]	15	17	88.2%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	3	5	60.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	21	25	84.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

1Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	14	25	56.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	5	17	29.4%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	1	0.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	22	22	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to	22	22	100.0%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.			
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	16	17	94.1%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	16	16	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	16	17	94.1%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	10	0.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	22	25	88.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	16	17	94.1%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	13	25	52.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	25	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	25	0.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	13	16	81.3%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	1	1	100.0%
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	0	1	0.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	16	25	64.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	24	25	96.0%

2. Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in managed care and newly eligible for MLTSS (Group D). All 25 files were further reviewed for compliance in all six (6) categories.

	August 2021 - June 2022		
Assessment	**N**	**D**	**Rate**
Member had a Screening for Community Services Assessment requested.	19	25	76.0%
Screening for Community Services Assessment was submitted to DoAS by the 10th of the following month.	0	19	0.0%

	August 2021 - June 2022		
Member Outreach	**N**	**D**	**Rate**
The Care Manager contacted the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	20	25	80.0%

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	25	25	100.0%
Options Counseling was provided to the Member.	25	25	100.0%
Member was offered the participant direction option.	18	25	72.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	1	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	24	25	96.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had a completed, verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	20	25	80.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%

	August 2021 - June 2022		
Initial Plan of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member was assessed for PCA services within 45 days of enrollment into MLTSS.	10	25	40.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	0	0	N/A
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	24	25	96.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	24	24	100.0%
Member's residing in their community home had a Risk Assessment completed that included documentation of whether a positive risk was identified or not (not applicable for Members residing in CARS).	25	25	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	0	11	0.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).	25	25	100.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	16	25	64.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	25	0.0%
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	25	0.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	21	24	87.5%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

3. Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 54 files were reviewed for the Members enrolled in managed care and MLTSS prior to the review period (Group E) and 4 files were excluded. Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Group E were not evaluated for elements in the Assessment category. Initial Member Outreach is not assessed for Members in Group E. All 50 files were reviewed for compliance in four (4) categories.

	August 2021 - June 2022		
Telephonic Monitoring or Face-to-Face Visits	**N**	**D**	**Rate**
Member (or Member's Representative) was present for, and included in, all telephonic meetings with the Care Manager.	50	50	100.0%
Options Counseling was provided to the Member.	45	50	90.0%
Member was offered the participant direction option.[1]	32	49	65.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.	1	1	100.0%
Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	42	50	84.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

[1]Members residing in CARS are excluded from the denominator

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member had their annual Plan of Care reviewed within 30 days of the Member's anniversary (from the date of the Initial Plan of Care).	N/A[1]	N/A[1]	N/A[1]

	August 2021 - June 2022		
Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
PCA re-assessment was completed for changes in the Member's condition or living arrangements.	1	1	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	45	50	90.0%
Members who required a Back-up Plan, had a completed and signed/verbally acknowledged Back-up Plan using the State mandated form (not applicable for Members residing in CARS).	49	49	100.0%
Back-up Plan included actions that a Member should take to report any Gaps in Care to the Care Manager (not applicable for Members residing in CARS).	49	49	100.0%
Care Manager completed an Annual Risk Assessment for the Member (not applicable for Members residing in CARS.	44	49	89.8%
IPRO identified the Member as having a potential risk during the review period that the CM failed to identify.[2]	47	49	95.9%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all its components (not applicable for Members residing in CARS).	2	31	6.5%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	43	50	86.0%

[1]Due to the nature of the audit and the timeframe, this was not included in the current audit

[2]The numerator represents the Members that were identified by IPRO as having a potential risk that the Care Manager also identified

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	15	50	30.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	50	2.0%

	August 2021 - June 2022		
Ongoing Care Management	**N**	**D**	**Rate**
Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	17	49	34.7%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis (not applicable for Members residing in CARS).	38	49	77.6%
Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge.	3	3	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	1	1	100.0%

	August 2021 - June 2022		
Gaps in Care/Critical Incidents	**N**	**D**	**Rate**
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	50	98.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

4. Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS performance measures: #9a (Member's Plan of Care is amended based on change of Member condition), #10 (Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment), #11 (Plans of Care developed using "Person-Centered principles"), #12 (MLTSS HCBS Plans of Care that contain a Back-up Plan if required), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2021-2022 audit findings. Overall, the MCO's audit results ranged from 50% to 99% across all groups for five (5) performance measures for the current review period.

Table 4. Results of MLTSS Performance Measures: WCHP

Performance Measure	Group[1]	August 2021 - June 2022		
		N	**D**	**Rate**
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C			
	Group D			
	Group E			
	Ancillary Group C			
	Ancillary Group D			
	Total			
	Group C			

Performance Measure	Group[1]	August 2021 - June 2022		
		N	D	Rate
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[3]	Group D			
	Group E			
	Total			
#9a. Member's Plan of Care is amended based on change of Member condition[4]	Group C	0	1	0.0%
	Group D	0	0	N/A
	Group E	1	1	100.0%
	Total	1	2	50.0%
#10. Plans of Care are aligned with Members needs based on the results of the NJ Choice Assessment[5]	Group C	22	24	91.7%
	Group D	24	24	100.0%
	Group E			
	Total	46	48	95.8%
#11. Plans of Care developed using "Person-Centered principles"[6]	Group C	22	22	100.0%
	Group D	25	25	100.0%
	Group E	45	50	90.0%
	Total	92	97	94.8%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	16	17	94.1%
	Group D	24	25	96.0%
	Group E	49	49	100.0%
	Total	89	91	97.8%
#16. Member training on identifying/reporting critical incidents	Group C	24	25	96.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	99	100	99.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]This measure was not calculated during this review
[3]This measure was not calculated during this review
[4]Members who did not have a documented change in condition during the study period are excluded from this measure
[5]Group E Members are excluded from this measure
[6]In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[7]Members in CARS are excluded from this measure
N/A: Not applicable

Discussion

Limitations

Due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. In 2021, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to evaluate the audit elements relative to the impact of the pandemic. Supplemental elements were added to evaluate the MCOs response to the COVID-19 pandemic, while other elements were removed because certain Care Management activities could not be conducted for the entirety of the review period. Similarly, some audit elements were revised to allow for process changes because of the suspension of in-person Care Management activities.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Due to the suspension of certain Care Management activities including the New Jersey Choice Assessment, Members in Groups C and E were not evaluated for elements in the Assessment category. For Group D, the MCO had a score of 43.2% in the Assessment category.

Group	8/21 to 6/22
Group C	
Group D	43.2%
Group E	
Combined	43.2%

Opportunities for Improvement for elements of the *Assessment* category include the following:

- Group D: WellCare should ensure that a Screening Community Service Assessment (SCS) is utilized to identify potential MLTSS needs and should be submitted by the 10th of the month following completion of the SCS.

Member Outreach

Across groups, the MCO had a combined score of 70.0% in the Member Outreach category.

Group	8/21 to 6/22
Group C	60.0%
Group D	80.0%
Group E[1]	
Combined	70.0%

[1]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements of the *Member Outreach* category include the following:

- Group C: WellCare should ensure the Care Manager initiates contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.

- Group D: WellCare should ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.

Telephonic Monitoring or Face-to-Face Visits

Across all three groups, the MCO had a combined score of 87.9% in the Telephonic Monitoring Visits category.

Group	8/21 to 6/22
Group C	89.7%
Group D	92.1%
Group E	85.0%
Combined	87.9%

Opportunities for Improvement at the group level for elements of the *Telephonic Monitoring or Face-to-Face Visits category with a score below 86%* include the following:

- Group E: WellCare should ensure the Member is offered the participant direction option. WellCare should ensure the Member has a cost neutrality analysis on file during the review period and include a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.

Initial Plan of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 86.9% in the Initial Plan of Care (Including Back-up Plans) category.

Group	8/21 to 6/22
Group C	80.2%
Group D	86.4%
Group E	90.0%
Combined	86.9%

Opportunities for Improvement at the group level for elements of the *Initial Plan of Care (Including Back-up Plans) category with a score below 86%* include the following:

- Group C: WellCare should ensure the Member has a completed, signed/verbally acknowledged Initial Plan of Care on file that is provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program. WellCare should ensure the Member is assessed for PCA services within 45 days of enrollment into MLTSS. WellCare should ensure that Members who have a change in condition or living arrangements have a PCA re-assessment. WellCare should ensure that Members who are identified as having a positive risk, have a signed/verbally acknowledged Risk Management Agreement with all of its components on file (not applicable for Members residing in CARS).

Ongoing Care Management

Across all three groups, the MCO had a combined score of 41.4% in the Ongoing Care Management category.

Group	8/21 to 6/22
Group C	39.6%
Group D	50.0%
Group E	37.1%
Combined	41.4%

Opportunities for Improvement for elements of the *Ongoing Care Management* category include the following:

- Group C: WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the Community. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.

- Group D: WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.

- Group E: WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. WellCare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the Community.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 94.5% in the Gaps in Care/Critical Incidents category.

Group	8/21 to 6/22
Group C	80.0%
Group D	100.0%
Group E	99.0%
Combined	94.5%

Opportunities for Improvement for elements at the group level of the *Gaps in Care/Critical Incidents category with a score below 86%* include the following:

- Group C: WellCare should ensure the Care Manager has documentation that they reviewed with the MLTSS Members receiving services, the process of immediately reporting gaps in service delivery (excludes Members residing in CARS).

Performance Measures

Overall, the MCO scored below 86% in one (1) of the five (5) performance measures.

- PM #9a: Member's Plan of Care is amended based on change of Member condition

Opportunities for Improvement for Performance Measures include the following:

- Group C: PM #9a: WellCare should ensure the Member's Plan of Care is amended based on change of Member needs or condition.

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

WellCare Health Plans of New Jersey, Inc.
Managed Long Term Services and Supports (MLTSS)
2022 Annual Assessment Review of
Care Management

Review Period - July 1, 2021 to June 30, 2022

January 2023

IPRO
Better healthcare, realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

Introduction……4

Care Management and Continuity of Care……6

List of Tables

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management……5

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care……6

Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

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

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by WellCare Health Plans of New Jersey, Inc. (WCHP) as evidence of compliance of the standards under review; interviews with key WCHP staff (held via WebEx on January 10, 2023) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on October 21, 2022 and received from the MCOs on November 4, 2022. The documentation review occurred at the IPRO office in New Jersey beginning on November 7, 2022. The offsite review team was made up of Carla Zuccarello, Cynthia Steffe, and Donna Reinholdt. The Care Management assessment covered the period from July 1, 2021 to June 30, 2022. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met	All parts within this element were met.	Full
Total Met	This element was met among the elements subject to review in the current review period; or this element was met in the previous review period and was not subject to review in this review period.	Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Subject to Review	This element is subject to review in the current review cycle.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review cycle and was met.	Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2022 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. WCHP received an overall compliance score of 100% in 2022. In 2021, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Subject to Review	Met	Not Met	N/A	Deficiency Status		
						Prior	Resolved	New
CM18b	X	X	X	-	-	-	-	-
CM28	X	X	X	-	-	-	-	-
CM29	X	X	X	-	-	-	-	-
CM30	X	X	X	-	-	-	-	-
CM31	X	X	X	-	-	-	-	-
CM32	X	X	X	-	-	-	-	-
CM34	X	X	X	-	-	-	-	-
CM36	X	X	X	-	-	-	-	-
CM37	X	X	X	-	-	-	-	-
CM38	X	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage			**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit
WellCare Health Plans of New Jersey, Inc.

December 2022

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1 through June 30th. Due to COVID-19, the prior review period was from July 1, 2019 through February 29th, 2020. An extension period was included through March 1, 2020 through December 31st, 2020 to assess activities during the period when access to nursing facilities was restricted. The review period for this audit was Janaury 1, 2021 through August 14, 2021. During that time, access to nursing facilities continued to be restricted. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the MCO Contracts, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated January 2021 through August 2021. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and Contract references. In 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS NF/SCNF Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020 where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for Institutional Settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to the NF/SCNF. MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS enrollment and to identify MLTSS NF/SCNF enrollment. The sample included in the study was selected by using the following capitation codes to identify MLTSS HCBS and NF/SCNF enrollment (**Table 1**) and applying the sampling methodology described below.

Table 1. Capitation Codes

Cap Code	Description
Identification of MLTSS HCBS enrollment	
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS
Identification of MLTSS NF enrollment	
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for WellCare Health Plans of New Jersey, Inc. (WCHP), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population are as follows:

- The member must have been enrolled in MLTSS on August 14, 2021, and
- The member must have been enrolled as a NF/SCNF member for six (6) consecutive months during the review period and still with the MCO of record on August 14, 2021, and
- The member cannot have been enrolled with another MCO at any time between the beginning of the minimum six (6) month NF/SCNF enrollment and the end of the review period (August 14, 2021).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the following four subgroups:

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021 with the MCO of record on December 31, 2021
Group 2	Members residing in a NF/SCNF for at least six (6) consecutive months between January 1, 2021 and August 14, 2021, and transitioned to HCBS during the review period with no transition from HCBS to another nursing facility
Group 3	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, and transitioned to a NF/SCNF for at least six (6) consecutive months during the review period (and was still residing in the NF/SCNF as of August 14, 2021)
Group 4	Members residing in HCBS for at least one month between January 1, 2021 and August 14, 2021, transitioned to a NF/SCNF for at least six (6) consecutive months, and transitioned back to HCBS for at least one month during the review period

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date
- Description of the sample
- File listing identifying the files that needed to be submitted to IPRO as well as instructions for preparing files, and uploading the files to IPRO's FTP site

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for WCHP, 100 member files were reviewed and included in the results pertaining to the Plan of Care for Institutional Settings. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" (not applicable) were not included in scoring. Population results, as shown in **Tables 2a-e**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

A total of 100 files were reviewed for requirements regarding Plans of Care for Institutional Settings, Transition Planning, Reassessment of the POC and Critical Incident Reporting (see **Tables 2a-e**). Based on sample selection criteria, this includes all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report.

Tables 2a-e

Table 2a.

Facility and MCO Plan of Care	Review Period (January 1, 2021-August 14, 2021)		
	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	64	100	64.0%
Documented Review of the Facility Plan of Care by the Care Manager	60	64	93.8%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	55	64	85.9%

Table 2b.

MLTSS Initial Plan of Care and Ongoing Plans of Care	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
The Member's **individualized Plan of Care** (including obtaining Member's signature**) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS)	1	2	50.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services	77	100	77.0%
Care Manager arranged Plan of Care services using both formal and informal supports	77	100	77.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process	77	100	77.0%
Plan of Care that was given to the member contained goals that met all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this)	77	100	77.0%
Documentation of the Member's agreement/disagreement with the POC statements were documented on the Member's POC and maintained in the Member's electronic CM record	67	100	67.0%
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	0	CNC

CNC: Could not calculate

Table 2c.

Transition Planning	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	79	100	79.0%
Evidence of the **Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	7	100	7.0%
Member was present at each telephonic visit or was involved from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in a telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	83	100	83.0%
Timely telephonic Review of Member Placement and Services. Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	78	100	78.0%
Members requiring coordination of care had coordination of care by the Care Manager	99	100	99.0%
Care Manager explained and discussed any payment liability with the Member if a member had any payment liability for the NF/SCNF admission	75	100	75.0%

Table 2d.

Reassessment of the POC and Critical Incident Reporting	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment	0	0	CNC
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	76	100	76.0%
Care Manager reviewed the Member's Rights and Responsibilities	78	100	78.0%
Care Manager educated the Member on how to file a grievance and/or an appeal	78	100	78.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	78	100	78.0%

CNC: Could not calculate

Table 2e.

PASRR Communication for Transitions to/from NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	N	D	Rate
Member was admitted to a NF/SCNF prior to the review period	N/A		
Member was admitted to an NF/SCNF during the review period	N/A		
Care Manager completed or confirmed PASRR Level I prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Care Manager completed or confirmed PASRR Level II if applicable, prior to Transfer to NF/SCNF	N/A	N/A	N/A
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	N/A	N/A	N/A
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	N/A	N/A	N/A

N/A: Not Applicable (PASRR questions were removed this year; Due to the COVID-19 pandemic, face-to-face visits were placed on hold)

MLTSS Members Transitioning between HCBS and NF/SCNF Settings

Of the cases selected for WCHP, 100 member files were reviewed and included in the results. Rates were calculated for State requirement-specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4).

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 3 and Table 4, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4). Rates were calculated to profile NF/SCNF members that transitioned to HCBS (**Table 3**).

Table 3. NF/SCNF Members Transitioned to HCBS

NF/SCNF Members Transitioned to HCBS	Review Period (January 1, 2021- August 14, 2021)		
	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	CNC
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	CNC
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	CNC
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	CNC
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	CNC
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	CNC
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	CNC

CNC: Could not calculate

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4). Rates were calculated to profile HCBS members that transitioned to a NF/SCNF (**Table 4**).

Table 4. HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	Review Period (January 1, 2021- August 14, 2021)		
	Groups 3, 4		
	N	D	Rate
Member had a person-centered transition plan on file	0	0	CNC
Member participated in a Therapeutic leave	0	0	CNC
Care Manager completed a Risk Management Agreement for the Member when indicated	0	0	CNC
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	CNC
Care Manager coordinated admission with DDD and or DMAHS for placement in a specialized services setting when indicated	0	0	CNC

CNC: Could not calculate

The expansion of the Nursing Facility audit components included evaluating the NF/SCNF Population on the MLTSS Performance Measures. There were no changes made to the applicable MLTSS Performance Measures for the current review period.

Population-specific findings are presented in **Table 5**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results, as shown in **Table 5**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 5** shows the results of the audit findings.

Table 5. Results of MLTSS Performance Measures: WCHP

Performance Measure	Group	January 2021 – August 2021		
		N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	Group 1	1	2	50.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	1	2	50.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group 1	78	100	78.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	78	100	78.0%
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group 1	0	0	CNC
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	0	0	CNC
#11. Plans of Care developed using "person-centered principles" [4]	Group 1	77	100	77.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	77	100	77.0%
#16. Member training on identifying/reporting critical incidents	Group 1	78	100	78.0%
	Group 2	0	0	CNC
	Group 3	0	0	CNC
	Group 4	0	0	CNC
	Total	78	100	78.0%

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

Limitations

The annual NF/SCNF CM Audit review period is from July 1st through June 30th. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. During the 2021 NF/SCNF CM Audit the MCOs were only evaluated based on scores from the review period (period through which they could conduct normal business activities) not the expansion period. The 2021 NF CM review period changed from a full year review to a partial year review beginning January 1, 2021 and ending August 14, 2021.

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions and Recommendations

Overall, the MCO scored 86% or above in the following review elements (**Table 2a-e**):

- Documented Review of the Facility Plan of Care (93.8%)
- Members requiring coordination of care had coordination of care (99.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Table 2a-e**):

- Copies of any Facility Plans of Care on file (64.0%)
- Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (50.0%)
- Care Managers used a person-centered approach (77.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (77.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process (77.0%)
- Plan of Care that was given to the member contained goals that met all the criteria (77.0%)
- Documentation of the Member's agreement/disagreement with the POC statements were documented (67.0%)
- Member was identified for transfer to HCBS and was offered options (79.0%)
- Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (7.0%)
- Member was present at each telephonic visit (83%)
- Timely Telephonic Review of Member Placement and Services (78%)
- Care Manager explained and discussed any payment liability (75.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative (76.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (78.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (78.0%)
- Member and/or representative had training on how to report a critical incident (78.0%)
- MLTSS Plan of Care on file (85.9%)

Recommendations for audit elements include the following:

WCHP's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The Care manager should use a person-centered approach while using both formal and informal supports. Member's Plan of Care should have developed goals that address the issues that are identified during the assessment and contain goals that met all criteria. WellCare should ensure that documentation of the Member's agreement/disagreement with the Plan of Care statements were documented, and Member was identified for transfer to HCBS and was offered options The. MLTSS Care Manager

should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually. WellCare should ensure timely telephonic review of member placement and services and the MLTSS Care Managers is to discuss payment liability. The Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. The Care Manager reviewed the Member's Rights and Responsibilities, educated the Member on how to file a grievance and/or an appeal and member and/or representative had training on how to report a critical incident.

Opportunities for improvement for Performance Measures that scored below 86% exist for the following PMs (**Table 5**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (50.0%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (78.0%)
- #11. Plans of Care developed using "person-centered principles" (77.0%)
- #16. Member training on identifying/reporting critical incidents (78.0%)

Recommendations for MLTSS Performance Measures include the following:

WCHP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS and should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary. The Care managers should use "person-centered principles" when developing their Plans of Care. WHCP MLTSS Care managers should ensure that member training on identifying/reporting critical incidents is being completed.

As presented in **Table 3**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to Home and Community Based Services (HCBS). Since no files were reviewed in this category, specific conclusions and recommendations could not be determined.

As presented in **Table 4**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix G: Supplemental Documents – Submission Guides for 2022 Annual Assessment Review and 2022 Care Management Audits (Core Medicaid and MLTSS)

Appendix G1

New Jersey Annual Assessment of MCO Operations

Core Medicaid and MLTSS Medicaid
Document Submission Guide
2022 – Full

NOTE: If your MCO has been effected by COVID-19 for any element, provide a detailed response in the narrative indicating why your MCO was unable to comply with that element. IPRO will evaluate elements within the context of potential COVID-19 impact where appropriate.

Access			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
A1	4.2.1.B	**4.2.1.B** **Emergency Services** The Contractor shall be responsible for emergency services, both within and outside the Contractor's enrollment area, as required by an enrollee in the case of an emergency. Emergency services shall also include: 1. Medical examination at an Emergency Room which is required by NJAC 10:122D-2.5(b) when a foster home placement of a child occurs after business hours. 2. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect. 3. Post-Stabilization of Care. The Contractor shall comply 42 CFR 438.114(e) and 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor's network if: a. The services were pre-approved by the Contractor or its providers; or b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care; or c. The Contractor could not be contacted for pre-approval. The Contractor's financial responsibility for post-stabilization care services, if not pre-approved, ends when: i. A physician in the Contractor's network with privileges at the treating hospital assumes responsibility for the Member's care. ii. A physician in the Contractor's network assumes responsibility for the Member's care through transfer.	• Policies and Procedures addressing the following: ➢ Emergency Care ➢ Access and Availability, and Primary Care Provider (PCP) After Hours Availability ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print

		iii. Contractor and the treating physician reach an agreement concerning the Member's care. iv. The Member is discharged.	
A2*	4.6.2.L	**4.6.2.L** **Emergency Care** The Contractor shall have methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.	▪ Policies and Procedures addressing the following for the Core Medicaid population and the MLTSS population ➢ Over/Under Utilization ▪ Over/Under Utilization Reports ▪ Provider Profiling Programs ▪ Provider Profiles ▪ ER Utilization Report ▪ ER Utilization Programs ▪ ER Initiatives Including Outcomes ▪ MLTSS Critical Incident Reports
A3	4.6.3	**4.6.3** **Referral Systems** A. The Contractor shall have a system whereby enrollees needing specialty medical, dental, behavioral health and/or long term services and supports will be referred timely and appropriately. The Contractor shall coordinate the referral process for members with substance use disorders (SUD) with the State's IME. The system shall address authorization for specific services with specific limits or authorization of treatment and management of a case when medically indicated. The Contractor shall maintain and submit a flow chart accurately describing the Contractor's referral system, including the title of the person(s) responsible for approving referrals. The following items shall be contained within the referral system: 1. Procedures for recording and tracking each authorized referral. 2. Documentation and assurance of completion of referrals. 3. Policies and procedures for identifying and rescheduling broken referral appointments with the providers and/or Contractor as appropriate. 4. Policies and procedures for accepting, resolving and responding to verbal and written Member requests for referrals made to the PCP and/or Contractor as appropriate. Such requests shall be logged and documented. Requests that cannot be decided upon immediately shall be responded to in writing no later than five (5) business days from the date of receipt of the request (with a call made to the Member on final disposition) and postmarked the next day. 5. Policies and procedures for proper notification of the Member and where applicable, authorized person, the Member's provider, and the	▪ Utilization Management (UM)/Care Management/Pharmacy Referral Policy and Procedures ▪ UM Program Description ▪ Policies and Procedures addressing the following: ▪ Accepting, resolving and responding to verbal and written enrollee requests for referrals made to the PCP and/or Contractor as appropriate ▪ Proper notification of the right to appeal and/or right to request a second opinion when services are denied ▪ Special Needs ▪ Identifying and rescheduling broken referral appointments ▪ Dental Specialty Needs ▪ Long term services and supports ▪ Complex Needs Assessment (CNA) Form ▪ Case Examples ▪ Referral process for MLTSS services; i.e., PDN, TBI therapies, ALR, etc. ▪ Evidence of tracking requests for referrals (including second opinions) to ensure referral timeliness; dates and methods of member/provider/internal communication, and outcome.

		Member's Care Manager, including notice of right to appeal and/or right to request a second opinion when services are denied. 6. A referral form which can be given to the Member or, where applicable, an authorized person to take to a specialist. 7. Referral form mailed, faxed, or sent by electronic means directly to the referral provider. 8. Telephoned authorization for urgent situations or when deemed appropriate by the Member's PCP or the Contractor. 9. Where applicable, the Contractor must also notify the Contractor Care Manager or authorized person. B. The Contractor shall provide a mechanism to assure the facilitation of referrals when traveling by an enrollee (especially when very ill) from one location to another to pick-up and deliver forms can cause undue hardship for the enrollee. Referrals from practitioners or prior authorizations by the Contractor shall be sent/processed within two (2) working days of the request, one (1) day for urgent cases. The Contractor shall have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care. C. The Contractor shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither the Contractor nor its vendor shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor its vendor shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. D. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. E. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for nonemergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.	▪ Evidence of tracking missed referral appointments and member/provider follow-up. ▪ Evidence of standing referrals to specialists in cases of ongoing specialty care. ▪ Medical and dental prior authorization procedures and guidelines for decision making. ▪ Utilization Management policies and procedures that demonstrate the UM denial process for medical and dental referrals.

A4*/**	4.5.1.F 4.8.1.A 4.8.1.E 4.8.1.J 4.8.3 4.8.3.D	**4.5.1.F** While the Contractor must assure that Enrollees with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. The Contractor, therefore, shall accept for network participation dental providers with expertise in the dental management of Enrollees with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. **4.8.1.A** **Provider Network** The Contractor shall establish, maintain and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access (in accordance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq.) to all services covered under this contract including those with limited English proficiency or physical or mental disabilities. 1. The provider network shall consist of traditional providers for primary and specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers (FQHCs), nursing facilities, residential setting providers for recipients of MLTSS, home and community based services providers and other essential community providers/safety-net providers, and ancillary providers. 2. The provider network shall be reviewed and approved by DMAHS and the sufficiency of the number of participating providers shall be determined by DMAHS in accordance with the standards found in Article 4.8.8 "Provider Network Requirements." 3. In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, the State shall require that, in order to participate as a provider in the Contractor's network that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under NJ FamilyCare and who are enrolled with the Contractor, the provider is enrolled consistent with section 1902(kk) with DMAHS. 4. The Contractor may execute network provider agreements, pending the outcome of section 1902(kk) screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately	▪ Access and Availability Policy and Procedure (GEO Access Reports) ▪ Network Development Policy and Procedure ▪ Provider Recruitment and Retention Committee Charter ▪ Provider Directory ▪ Screen print of the Provider Directory on the MCO Website ▪ Network of dental providers who provide care to special needs enrollees.

		upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the Provider, and notify affected Members. **4.8.1.E** The Contractor shall include in its network mental health/Substance Use Disorder providers for the Medicaid covered MH/SUD services (as stated in Article 4.1) with expertise to serve enrollees who are clients of the Division of Developmental Disabilities and providers for MH/SUD services (as stated in Article 4.4) for MLTSS Members. **4.8.1.J** The Contractor shall include in its network providers for Managed Long Term Services and Supports. The Contractor's network shall include all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0). **4.8.3** **Provider Network File Requirements** The Contractor shall provide a certified provider network file quarterly, to be reported electronically in a format and software application system determined by DMAHS that will include <u>every</u> provider including MLTSS, Behavioral Health (BH), and dental providers in the Contractor's network. The Contractor shall demonstrate its compliance with provider network requirements and how it will assure enrollee access to all benefits covered under this contract. **4.8.3.D** The quarterly provider file shall include a unique identifying number for each individual provider. The National Provider Identifier (NPI) for covered entities and the professional license number are required. Non Traditional Providers shall be identified with the provider's EIN, tax number, license number, UPIN, Medicaid provider number, Medicare provider number, and Social Security Number where applicable.	
A4a* – Core Medicaid PCPs - Adults			▪ GeoAccess Reports
A4b* – Core			▪ GeoAccess Reports

Medicaid PCPs – Pediatric			
A4c* – Core Medicaid Specialty Providers			▪ GeoAccess Reports
A4d* – Core Medicaid Dental/ Specialty Dental			▪ GeoAccess Reports
A4e* - Core Medicaid Hospitals			▪ GeoAccess Reports
A4f** – MLTSS Providers			▪ Provider Report/Grid of MLTSS Network
A5	4.8.1.L **4.5.3.A**	**4.8.1.L** **Enrollees with Special Needs** The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs. 1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home. 2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs. **4.5.3.A** **CLIENTS OF THE DIVISION OF DEVELOPMENTAL DISABILITIES** The Contractor shall provide all physical health services required by this contract as well as the MH/SUD services included in the Medicaid State Plan	▪ Policies and Procedures addressing the following: ➢ Access and Availability ➢ Credentialing /Recredentialing ➢ Specialized Network for DDD members ▪ Provider Manual ▪ Provider application (with special needs check list and age group physician treatments) ▪ Provider Contract ▪ Provider Directory ▪ Special Needs Survey

		to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. The Contractor shall include in its provider network a specialized network of providers who will deliver both physical as well as MH/SUD services, in accordance with Medicaid program standards to adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SUD services to clients of DDD until the behavioral health ASO is implemented.	
A6	4.8.4	**4.8.4** **Provider Directory Requirements** A. As cited by HHS in the ONC 21st Century Cures Act final rule (also published of the Federal Register) at 45 CFR170.215, Effective beginning January 1, 2021 (with enforcement date of July 1, 2021), Provider Directory Application Programming Interface (API) must be accessible via a public-facing digital endpoint on the payer's website to ensure public discovery and access. At a minimum, Contractors must make available via the Provider Directory API provider names, addresses, phone numbers, and specialties. All directory information must be made available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of Contractor receiving provider directory information or an update to the provider directory information. B. The Contractor shall maintain a web-based/on-line provider directory. DMAHS staff and HBC staff will access the web-based/on-line directory as needed to assist members. The web-based provider directories shall be maintained with updates made no later than every seven (7) days. C. Primary care providers and dentists/PCDs who will serve enrollees listed by • County, by city, by specialty • Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); website URLs as appropriate, telephone number; fax number if available; office	▪ Provider Directory

		hours at each location; whether the provider is accepting new enrollees, indicates whether a provider serves enrollees under the age of six, indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP or PCD. This shall include a separate listing of dental providers who: ➢ Provide mobile dental services through use of mobile equipment or van outside of an office/clinic in facilities, schools and residences. ➢ Provide dental services to members under the age of six (6). ➢ Provide dental services to members with intellectual and developmental disabilities. ➢ All of these listings shall be updated as needed and at a minimum annually. D. Contracted specialists and ancillary services providers who will serve enrollees • Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C. • MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), website URLs as appropriate, telephone number and fax number if available and information on service area and services offered and whether the provider is accepting new enrollees. • Behavioral Health Providers should be listed in on-line directory by the service description below: • Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization • Adult Mental Health Rehabilitation (AMHR) • Autism Treatment Services - ABA (Independent Practitioner) • Autism Treatment Services - ABA (Group Practice) • Autism Treatment Services - DIR (Independent Practitioner) • Autism Treatment Services - DIR (Group Practice) • Inpatient Psychiatric Hospital Care • Independent Practitioner(s) (Neuropsychologist; Psychiatry; NP Psychiatric MH; Neurology (Osteopaths Only); Psychologist) • Medication Monitoring • Outpatient Mental Health Hospital	

		• Outpatient Mental Health Independent Clinic • Partial Care SUD - Substance Use Disorder Providers should be listed in the on-line directory by the service description below: • Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 – WM • Non-Medical Detoxification / Non-Hospital based withdrawal management ASAM 3.7 – WM • Substance Use Disorder Short Term Residential (STR) ASAM 3.7 • Substance Use Disorder Long Term Residential (LTR) ASAM 3.5 • Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM • Substance Use Disorder Partial Care (PC) ASAM 2.5 • Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1 • Substance Use Disorder Outpatient (OP) ASAM 1 • Opioid Treatment Services ASAM OTP (Methadone Maintenance) • Opioid Treatment Services (Non-Methadone Maintenance) • Medication Assisted Treatment in Physician Office (w/ Navigator) • Medication Assisted Treatment in Physician Office (w/o Navigator) E. Subcontractors • Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.	
A7*	4.7.2.A.3 4.7.2.A.8 5.12 B.4.14.X.I B.4.14.XI Appendices	**4.7.2.A.3** **Appointment Availability Studies** The Contractor shall conduct a review of appointment availability and submit a report to DMAHS annually. The report must list the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review. **4.7.2.A.8** **Annual PCP After-Hour Availability Study** The Contractor shall conduct an annual PCP After-Hour Availability study in order to monitor availability and accessibility to primary care providers	▪ MCO Access Standards ▪ Provider Manual ▪ Provider Directory ▪ Member Handbook ▪ Member Newsletter ▪ Policies and Procedures addressing the following: ➢ Access and Appointment Availability Standards ➢ Appointment Scheduling Assistance ➢ PCP Appointment Availability ➢ Verification of Appointment Availability ▪ PCP Appointment Availability Audit tool, results and follow-up with non-compliant providers

		(PCPs). The study shall be designed to determine a provider's availability for telephone consultation after regular business hours. The Contractor shall survey, at a minimum, no less than 25% of its PCP network. The PCPs are to be randomly selected from the Contractor's provider network file. Providers shall be contacted after business hours or on weekends. Providers and staff should be asked to identify the system the office uses for telephone coverage after regular business hours. A telephone response should be considered acceptable/unacceptable based on the following criteria: Acceptable – An active provider response, such as: 1. Telephone is answered by PCP, office staff, answering service or voice mail. 2. The answering service either: • Connects the caller directly to the provider; • Contacts the PCP on behalf of the caller and the provider returns the call; or • Provides a telephone number where the PCP/covering provider can be reached. 3. The provider's answering machine message provides a telephone number to contact the PCP/covering provider. Unacceptable: 1. The answering service: • Leaves a message for the provider on the PCP/covering provider's answering machine; or • Responds in an unprofessional manner. 2. The provider's answering machine message: • Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. • Instructs the caller to leave a message for the provider. 3. No answer; 4. Listed number no longer in service;	▪ PCP After Hours Availability Audit tool, results and follow-up with non-compliant providers ▪ Call Center Performance Measures ▪ Call Center Monthly or Quarterly Performance Reports ▪ Telecommunications Device for the Deaf Contract

		5. Provider no longer participating in the Contractor's network; 6. On hold for longer than five (5) minutes; 7. Answering Service refuses to provide information for survey; 8. Telephone lines persistently busy despite multiple attempts to contact the provider. The Contractor shall submit a report of the results of the survey and its corrective action plan to the DMAHS annually. The report shall also include the methodology and sample size used for the survey. **5.12** **Appointment Availability** The Contractor shall have policies and procedures to ensure the availability of medical, mental health/substance use disorder (for DDD clients and MLTSS Members) and dental care appointments in accordance with the following standards: A. Emergency Services. Immediately upon presentation at a service delivery site. B. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening. C. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention. D. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits. E. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral. F. Urgent Specialty Care. Within twenty-four (24) hours of referral.	

		G. Baseline Physicals for New Adult Enrollees. Within one hundred-eighty (180) calendar days of initial enrollment. H. Baseline Physicals for New Children Enrollees and Adult Clients of DDD. Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. I. Prenatal Care. Enrollees shall be seen within the following timeframes: 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester J. Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar. K. Lab and Radiology Services. Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care. L. Waiting Time in Office. Less than forty-five (45) minutes. M. Initial Pediatric Appointments. Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees. N. For dental appointments, the Contractor shall be able to provide: 1. Emergency dental treatment no later than forty-eight (48) hours or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider. 2. Urgent care appointments within three days of referral. 3. Routine non-symptomatic appointments within thirty (30) days of referral. O. For MH/SUD appointments, the Contractor shall provide: 1. Emergency services immediately upon presentation at a service delivery site. 2. Urgent care appointments within twenty-four (24) hours of the request. 3. Routine care appointments within ten (10) days of the request.	

		P. Maximum Number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children. Q. For SSI and New Jersey Care – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment. **B.4.14.X.I** The MCO takes steps to promote accessibility of all services offered to Members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include: 1. The points of access to primary care, behavioral health, specialty care, inpatient services and MLTSS are identified for Members. 2. At a minimum, Members are given information about: a. how to obtain services during regular hours of operations; b. how to obtain emergency and after-hours care; c. how to obtain second opinions; d. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care; e. how to select a PCP from among those accepting new enrollees; and. f. physical accessibility. **B.4.14.XI** The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and Member service lines and MLTSS contact lines). Performance on these dimensions of access are assessed against the standards.	
A8*	**4.7.4.A**	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion

		the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Quality Assessment and Performance Improvement			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Q1*	4.6.1.A	**4.6.1.A** **Quality Assessment and Performance Improvement Plan** The Contractor shall implement and maintain a Quality Assessment and Performance Improvement (QAPI) program that is capable of producing prospective, concurrent, and retrospective analyses. Delegation of any QAPI activities shall not relieve the Contractor of its obligations to perform all QAPI functions.	▪ Quality Management/Quality Assurance Program Description ▪ QI Work Plan - Previous year and current ▪ Quality Management Program Evaluation for the previous year ▪ Entire Year of the most recent Meeting Minutes – QI, Provider Advisory, etc. ▪ Various committee meeting minutes (e.g., QI, Provider Advisory, etc.) that may demonstrate oversight.
Q2*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall carry out the activities described in its QAPI. The Contractor shall develop and submit to DMAHS and/or the EQRO at the direction of the State, an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including MLTSS-related quality activities.	▪ QI/Annual Work Plan – previous year and current ▪ Documentation demonstrating implementation and evaluation of the plan ▪ Documentation demonstrating the inclusion and implementation evaluation **of MLTSS related activities in QAPI.**
Q3*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall also prepare and submit to DMAHS and/or the EQRO at the direction of the State, an annual report on quality assurance activities which demonstrate the Contractor's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.	▪ QI Program Evaluation for previous year ▪ Annual Quality Reports
Q4*	B.4.14.II.A-G Appendix	**B.4.14.II.A-G** The Quality Assessment and Performance Improvement program has written guidelines for its quality of care studies and related activities which include: A) specification of clinical or health services delivery areas to be monitored; B) use of quality indicators; C) use of clinical care standards/practice guidelines; D) analysis of clinical care and related services;	▪ QI Program Description - Current ▪ QI Work Plan - Previous year and current ▪ Clinical Studies and Projects Policy and Procedure ▪ Desk top procedures

		E) implementation of remedial/corrective actions; F) assessment of effectiveness of corrective actions; and G) evaluation of continuing and effectiveness of the QAPI.	
Q5*	B.4.14.II Appendix	**B.4.14.II** The Quality Assessment and Performance Improvement program objectively and systematically monitors and evaluates the quality and appropriateness of care and service, including MLTSS, to enrollees, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.	▪ QI Program Description ▪ QI Work Plan
Q6*	B.4.14.VI Appendix	**B.4.14.VI** The Quality Assessment and Performance Improvement program has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.	▪ Current QI Program Description ▪ Quality Management Organizational Chart ▪ Departmental job descriptions or bios
Q7*	B.4.14.VII.A B.4.14.VII.E Appendices	**B.4.14.VII.A** Participating physicians and other providers are kept informed about the written QA plan. **B.4.14.VII.E** The MCO has a description of how providers are to be involved in the design, implementation, review and follow-up of quality activities.	▪ QI Program Description ▪ Provider Manual ▪ Provider Newsletters ▪ Screen Prints of the MCO's – Provider Website ▪ PAC Charter ▪ Entire Year of the most recent Provider Advisory Committee (PAC) Meeting Minutes, Agendas, and Attendance Sheets
Q8*	B.4.14.XV.A Appendix	**B.4.14.XV.A** **Scope** The MCO shall document that it is monitoring the quality of care across all services, including MLTSS, and all treatment modalities, according to its written Quality Assessment and Performance Improvement plan. (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agenda, Attendance Sheets ▪ QI Program Evaluation for previous year ▪ Member Quality of Care Compliant Analysis ▪ Quarterly and Annual Quality of Care Reports MLTSS related reports
Q9*	B.4.14.XVI Appendix	**B.4.14.XVI** The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels. A. QA information is used in recredentialing, recontracting and/or annual performance evaluations. B. QA activities are coordinated with other performance monitoring activities, including utilization management, Care Management, risk management, and resolution and monitoring of Member grievances.	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ QI Program Evaluation for previous year

		C. There is a linkage between QA and the other management functions of the health plan such as: 1. network changes; 2. benefits redesign; 3. medical management systems (e.g., pre-certification); 4. practice feedback to physicians; 5. patient education; 6. Member services, and; 7. Care Management including MLTSS Care Management.	
Q10*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Quality Management			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6	**4.6** A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicaid and NJ FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports. B. The Contractor shall use its best efforts to ensure that persons and entities providing care and services for the Contractor, including long-term services and supports, in the capacity of physician, dentist, CNP/CNS, physician's assistant, CNM, or other medical service professional meet applicable licensing, certification, or qualification requirements under New Jersey law or applicable state laws in the state where service is provided, and that the functions and responsibilities of such persons and entities in providing medical, behavioral, dental and/or MLTSS care and services under this contract do not exceed those permissible under New Jersey law. This shall also include knowledge, training and experience in providing care and services to individuals with special needs as well as services provided by non-traditional MLTSS service providers.	
QM1	4.6.2.A	**4.6.2.A**	▪ Provider Manual

		Guidelines The Contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.	▪ Documentation showing how providers are notified of guideline updates including MLTSS. ▪ Provider/Member Newsletter ▪ Screen Prints of MCO Provider Website with list of Clinical Practice Guidelines ▪ Policies and Procedures addressing the following: ➢ Clinical Practice Guidelines ▪ Individual Practice Guidelines ▪ MLTSS Guidelines
QM2	4.6.2.B	**4.6.2.B** **Treatment Protocols** The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning and contributing family and social factors.	▪ Care Management /UM Workflow Diagrams ▪ QI or UM Program Descriptions ▪ Redacted cases showing adjustments based on the enrollee's medical condition and/or contributing family and social factors ▪ Policies and Procedures addressing the following: ➢ Treatment Protocol Adjustment
QM3*	4.6.2.C	**4.6.2.C** **Monitoring** The Contractor shall have procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.	▪ Clinical Practice Guidelines ▪ HEDIS® and CAHPS® Results and Analysis ▪ Provider Profiles ▪ Utilization Reports specific to individual providers ▪ UM Program Description ▪ QI Program Description ▪ QI Work Plan ▪ Provider Profiling Program ▪ Provider files to demonstrate corrective action taken to bring practitioner into compliance with clinical practice guidelines or average utilization of services
QM4*	4.6.2.D	**4.6.2.D** **Focused Evaluations** The Contractor shall have procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied. The Contractor shall also have procedures for conducting problem-oriented clinical studies of individual care.	▪ QI Program ▪ QI Program Evaluation ▪ Quality of care case examples and tracking ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Policies and Procedures addressing the following: ➢ Quality of Care ➢ Over/Under Utilization ➢ Emergency Room Utilization ➢ Monitoring of Mortality Rates

			▪ Credentialing - Covers the monitoring of quality of care concerns during the re-credentialing process ▪ Provider Monitoring Reports
QM5*	4.6.2.E	**4.6.2.E** **Follow-up** The Contractor shall have procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution shall follow the standard described in Article 5.15B.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service ▪ Grievance Database Report/Logs ▪ Example of a Grievance Acknowledgement Letter ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Blinded Case Example of Quality of Care Concern
QM6	4.6.2.F	**4.6.2.F** **Hospital Acquired Conditions and Provider–Preventable Conditions** The Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR 434, 438, and 447. Policies and procedures shall be submitted to the DMAHS for review and approval prior to implementation of the Contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes. The Contractor shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. The Contractor shall identify Other Provider-Preventable Conditions for non-payment as wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html	▪ Policies and Procedures addressing the following: ➢ Hospital Acquired Conditions ➢ Claims Payment ▪ Quality Outcomes Reports ▪ Denial Letters ▪ Educational Materials
QM7	4.6.2.G	**4.6.2.G** **Data Collection** The Contractor shall have procedures for gathering and trending data including outcome data.	▪ Policies and Procedures addressing the following: ➢ Data Collection Methods ➢ Analysis of Outcome Data ▪ Work Plans ▪ QI Program Description ▪ QI Program Evaluation ▪ Monitoring Reports ▪ ER utilization Reports ▪ Enrollee & Provider Grievances Policy and Procedure

QM8*	4.6.2.H	**4.6.2.H** **Mortality Rates** The Contractor shall review inpatient hospital mortality rates of its enrollees.	▪ Policies and Procedures addressing the following: ➢ Quality of Care ▪ Monthly Mortality Reports ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Flowcharts, Algorithm ▪ QI Program Description ▪ QI Work Plan ▪ QI Program Evaluation ▪ Mortality Initiatives Including Outcomes
QM9*	4.6.2.I	**4.6.2.I** **Corrective Action** In compliance with 42 CFR 438.230(b)(4), the Contractor shall have procedures for informing subcontractors and providers of identified deficiencies, or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes. The Contractor shall conduct reassessments to determine if corrective action yields intended results.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service and/or Flowchart ➢ Credentialing/Recredentialing ➢ Corrective Action Plan procedure if separate from Quality of Care Policy and Procedure ▪ Request for a Corrective Action Plan (CAP) Letter to provider ▪ CAP Reminder Letters ▪ CAP Approval Letter; Closure Letter to provider ▪ Entire Year of the most recent Oversight Committee Meeting Minutes ▪ Confirmed Quality of Care Case Example
QM10	4.6.2.M	**4.6.2.M** **New Medical Technology** The Contractor shall have policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and durable medical equipment (DME).	▪ Policies and Procedures addressing the following: ➢ Technology Assessment ➢ Decisions Policy ▪ Evidence-based literature from peer-reviewed journals ▪ Provider Manual ▪ Provider Newsletters ▪ Entire Year of the most recent Oversight/New Technology Committee Meeting Minutes
QM11a*	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must	▪ Core Medicaid PIP Submission Worksheets or Other PIP Documentations ▪ Core Medicaid Special Initiatives Including Outcomes

		conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	
QM11b**	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	▪ MLTSS PIP Submission Worksheets or Other PIP Documentations ▪ MLTSS Special Initiatives Including Outcomes
QM12*	4.7.2.D	**4.7.2.D** The Contractor shall conduct reviews/audits which focus on the special dental needs of enrollees with developmental disabilities. Using encounter data reflecting the utilization of dental services and other data sources, the Contractor shall measure clinical outcomes; have these outcomes evaluated by clinical experts; identify quality management tools to be applied; and recommend changes in clinical practices intended to improve the quality of dental care to enrollees with developmental disabilities.	▪ Encounter Data Reports/Other Data Reports ▪ Audit Procedure ▪ Most recent Audit Results ▪ Dental Initiatives for enrollees with Developmental Disabilities including outcomes
QM13*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
QM14	4.2.6.B.1.d	**4.2.6.B.1.d** Section 1905(r) of the Social Security Act (42 U.S.C. § 1396(d) and federal regulation 42 C.F.R. § 441.50 et seq. requires EPSDT services to include:	▪ QI Evaluation ▪ Data Reports

		1. d. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by the Contractor. The following list of screening tests is not all inclusive: ▪ Hemoglobin/hematocrit/EP ▪ Urinalysis ▪ Tuberculin test – intradermal, administered annually and when medically indicated ▪ Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child: - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age - at 18-26 months, preferably at twenty-four (24) months of age - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested ▪ Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.	
QM15	4.2.6.B.9.a,b	**4.2.6.B.9.a,b** **Lead Screening** The Contractor shall provide a screening program for the presence of lead toxicity in children which shall consist of two components: verbal risk assessment and blood lead testing. a. Verbal Risk Assessment – The provider shall perform a verbal risk assessment for lead toxicity at every periodic visit to children at least six (6) months and less than seventy two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions: i. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint? ii. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint? iii. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling? iv. Have any of your children or their playmates had lead poisoning? v. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community. vi. Do you give your child home or folk remedies that may contain lead? Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answer to all questions are	▪ QI Program Description ▪ QI Evaluation ▪ Policy and Procedures

		negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child must be tested according to age groups specified in 4.2.6.B.8.b. A child's risk category can change with each administration of the verbal risk assessment. b. Blood Lead Testing – All screening must be done through a blood lead level determination. The Contractor must implement a screening program to identify and treat high-risk children for lead-exposure and toxicity. The screening program shall include blood level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. A confirmatory blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, and once between 18-26 months, preferably at twenty-four (24) months If a child between the ages of twenty four (24) months and seventy two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages than stated in 4.2.6.B.1.d. i. If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed according to the schedule in 4.2.6.B.8.	

		ii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing. iii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, the contractor should recommend a follow-up venous blood screening for the child, and blood lead testing for the other children and pregnant women living in the household. iv. When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, the contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation. v. When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, the Contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding the child's care, including the scheduling and results of follow-up blood lead tests. vi. When laboratory results are received, the Contractor shall require PCPs to report to the Contractor all children with blood lead levels > 5 µg/dl. Conversely, when a provider other than the PCP has reported the lead screening test to the Contractor, the Contractor shall ensure that this information is transmitted to the PCP.	
QM16	4.2.6.B.9.c	**4.2.6.B.9.c** c. On a semi-annual basis, the Contractor shall outreach, via letters and informational materials to parents/custodial caregivers of all children enrolled in the Contractor's plan who have not been screened, educating them as to the need for a lead screen and informing them how to obtain lead screening and transportation to the screening location.	▪ QI Program Description ▪ Policy and Procedures ▪ Outreach Reports ▪ Member Letters ▪ Member Educational Materials
QM17	4.2.6.B.9.d	**4.2.6.B.9.d** d. On an annual basis, the Contractor shall send letters to PCPs who have lead screening rates of less than 80% for two consecutive six-month periods, educating them on the need and their responsibility to provide lead screening services. The eligible population of children shall be identified using methodology as defined by the State.	▪ QI Program Description ▪ QI Program Evaluation ▪ Policy and Procedures ▪ Reports ▪ Provider Letters ▪ Provider Educational Materials
QM18*	4.6.2.P	**4.6.2.P** **PERFORMANCE MEASURES**	▪ TPL Allocation Table ▪ Member Level Files ▪ HEDIS Roadmap

		The Contractor shall submit to DMAHS and/or the EQRO at the direction of the State, annually, on a date specified by the State, performance measures in accordance with the following: 1. HEDIS and NJ Specific Performance Measures. a. HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the Contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS). b. HEDIS reporting requirements shall be consistent with National Committee for Quality Assurance (NCQA) requirements found in the current HEDIS Technical Specifications. Measure rotation is not permitted. c. Electronic Submission requirements include: • HEDIS ROADMAP; • Complete HEDIS Workbook; • Interactive Data Submission System (IDSS) results; • Final Audit Report; • Source Code; • New Jersey Performance Measures results; • Member level data for select HEDIS and New Jersey Specific measures, at the discretion of the State, per EQRO file layout and submission instructions; and • A table that delineates how the populations are defined and included or excluded from performance measures following yearly guidance provided by the State and/or EQRO. d. Contractors must comply with all audit standards and requirements determined by NCQA. e. Contractors must comply with Medicaid reporting requirements, including but not limited to beneficiary category assignments as defined by the State. f. HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook. g. New Jersey Performance Measures o Annual Preventive Dental Visits - by Dual, Disability, Other and Total categories (all duals must be included in this measure) o Age Appropriate Blood Lead Testing in Children (Multiple Lead Testing in Children through 26 months of age) h. Following yearly guidance provided by the State and/or EQRO, Contractors shall submit a Workplan by each August 15th, or other time period as requested by the DMAHS. At the State's discretion, a CAP may be	▪ Locked IDSS ▪ CSV Data File ▪ ART ▪ Final Audit Report ▪ NJ Specific Measures ▪ Source Code as needed For Core Set Measure(s): ▪ Member Level Files ▪ Source Code as needed ▪ Rate Tables ▪ Workplans and/or CAPs as needed

		required. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where services are potentially below quality standards. These performance standards will reflect the minimum acceptable service level. The performance standards may be revised as necessary to ensure that they are reasonable and accurately reflect quality expectations. The Contractor shall provide updates as requested by the State to confirm the progress of the interventions proposed to the DMAHS. 2. Core Set Measure(s) a. Following yearly guidance provided by the State and/or EQRO, the Contractor shall submit specified Core Set Measures. Electronic submission requires member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions. b. At the State's discretion, a Workplan and/or CAP may be requested of the MCOs if the performance does not reflect the minimal acceptable service level.	
QM19**	9.11.F	**9.11.F** **MLTSS Performance Measures** The Contractor shall comply with all quality metric reporting requirements, including but not limited to: a. Contractor shall utilize the State's electronic templates for Performance Measures (PMs) b. Contractor shall comply with the EQRO PM validation process c. Contractor shall comply with the State's requirements for timeliness, accuracy, and quality of report submissions.	▪ Process description for production of each MLTSS performance measure ▪ Source Code (as required) ▪ Data sources used in producing the measures ▪ Preliminary rates (sample file) for all measures ▪ Member/Event-level detail files NOTE: If the above documents have been submitted for all MLTSS PMs during the review period, do not submit again. • Report of all submissions (monthly, quarterly and annual) of MLTSS measures during the review period showing date due to State, date initially submitted to IPRO, and date initially submitted to State.
QM20	4.2.6.A .a-b 4.2.6.B.3.a.i 4.2.6.B.3.a.ii	**4.2.6.A a-b** The contractor shall provide all PCDs on a quarterly basis a list of the PCD's enrollees who have not complied with the NJFC requirement (4.2.6.B) for dental services beginning by the age of 12 months or who have not had a subsequent dental visit for oral evaluation or preventive service bi-annually. The PCD shall be required to contact these Enrollees to schedule an appointment. Documentation by the PCD of outreach efforts and responses in the patient's record is required.	▪ Provider training on Dental EPSDT requirements. ▪ Evidence of tracking Dental EPSDT services. ▪ Monitoring Reports on PCP Dental referrals based on EPSDT requirements. ▪ Referrals during PCP visits for dental follow-up.

		a. When Enrollees are assigned a PCD, the list will be generated based on assignment. b. When Enrollees are not assigned a PCD, the list will be generated for the dentist based on Enrollee's previous 12 months claim history. **4.2.6.B.3.a.i** A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory. **4.2.6.B.3.a.ii** Follow up at well child visits through the age of twenty (20) to determine at a minimum dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided.	▪ Provider Site Visit Audit Tool showing evidence of NJ Dental EPSDT requirements ▪ Most recent Medical Record Review audit findings.

Efforts to Reduce Healthcare Disparities

2022 Element	Contract Reference	Contract Requirement Language	Documentation Examples
D1*	4.6.2.T.1 4.6.2.T.2	**4.6.2.T.1** The contractor shall develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following: 1. Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including: gender, race, ethnicity, primary language, geographic location, and disability status; **4.6.2.T.2** 2. Barrier analysis and a written action plan to address the disparities identified;	▪ Reports and Analysis conducted by the plan to identify disparities ▪ Action Plan to address disparities identified ▪ Policies and Procedures related to the identification of disparities
D2*	4.6.2.T.3	**4.6.2.T.3** 3. Implementation of an action plan with continuous monitoring of outcomes; and	▪ Disparities in the healthcare workplan ▪ Documentation demonstrating incorporation of disparities in healthcare into plan activities
D3*	4.6.2.T.4	**4.6.2.T.4** 4. Ongoing evaluation of the effectiveness of the action plan	▪ Policies and Procedures relating to the identification and monitoring of disparities in healthcare ▪ Disparities in the healthcare workplan ▪ Reports and Analysis conducted by the plan to re-evaluate disparities in healthcare

D4*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
D5*/**	**4.6.2.Q.5**	**4.6.2.Q.5** **Performance Improvement Project Categories.** PIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years. PIPs are to be implemented for NJ FamilyCare/Medicaid Members. At least one PIP must include activities that identify and reduce health care disparities.	▪ MCOs PIP submissions should clearly identify and reduce healthcare disparities.
Committee Structure			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CS1*	4.2.9	**4.2.9** The Contractor shall identify relevant community issues (such as TB outbreaks, violence, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and, issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program	▪ Community Needs Assessment from State and local governmental agencies ▪ QI Program Description ▪ QI Work Plan ▪ List/Schedule of Community Outreach Activities for the previous year and planned for the upcoming year ▪ Tracking Log of Completed Activities ▪ Community Needs Assessment from State and local governmental agencies ▪ HEDIS® and CAHPS® Results and Analysis ▪ Entire year of the most recent meeting minutes showing discussion of activities

		proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include: 1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs. 2. Guidelines for Member referral. 3. Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and Contractor's guidelines for assessment and referral. 4. Embedding information about evidence-based programs in provider and Member training initiatives. 5. A tracking mechanism for referral and program completion. 6. Designation of a liaison to DHS for evidence-based disease prevention. Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or certified nutritionist to complement traditional medical interventions in diabetes treatment, including but not limited to Diabetes Self-Management Education Programs, Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). E. Signs and symptoms of common diseases and complications F. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness G. Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish), Diabetes Self-Management Program (DSMP), Medical Nutritional Therapy (MNT), Diabetes Prevention Programs (DPPs) and Expanded Diabetes Prevention Programs (EDPPs). H. In accordance with P.L. 1968, c. 413, as amended by P.L. 2017, c. 161, the DSME program shall meet current quality standards established by either the American Association of Diabetes Educators (AADE) or the American Diabetes Association (ADA). DSME quality standards shall be based on the 2012 National Standards of DSME, any subsequent updates to these standards and other measures required by the AADE/ADA.	

		I. MNT shall be consistent with evidence-based nutrition practice guidelines published by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association). J. Prevention and treatment of alcohol and Substance Use Disorder K. Coping with losses resulting from disability or aging L. Self-care training, including self-examination M. Need for clear understanding of how to take over-the-counter and prescribed medications and the importance of coordinating all such medications N. Understanding the difference between emergent, urgent and routine health conditions O. Information and education on good oral hygiene practices and habits, and the need for regular dental visits and completion of treatment as prescribed by a dentist. P. Strategies to reduce the risk of unintentional injuries.	
CS2*	4.6.1.C.1 4.6.1.C.2 4.7.2.A.6 B.4.14.IV A-E B.4.14.V Appendices	**4.6.1.C.1** **QM Committee** The Contractor shall have adequate general liability insurance for Members of the QM committee and subcommittees, if any. The committee shall include representation by providers who serve enrollees with special needs and those eligible for MLTSS. **4.6.1.C.2** **Medical Director(s):** The Contractor shall have at least one on-site Medical Director(s) currently licensed in New Jersey as a Doctor of Medicine or Doctor of Osteopathic Medicine. The Contractor shall determine the requisite number of additional Medical Director(s) necessary to ensure the delivery of integrated medical, behavioral, and dental and MLTSS services. The Contractor shall ensure that Medical Director(s) have training and experience including but not limited to, serving populations: • With chronic health care conditions • With co-occurring medical and behavioral health disorders • With physical and or intellectual disabilities • Who meet or are at risk to meet nursing facility level of care The Medical Director(s) shall be responsible for: a. The development, interpretation and implementation of medical, behavioral and dental health policies and procedures to guide and support the provision of medical, behavioral and dental care to enrollees;	▪ QI Program Description ▪ QI Work Plan ▪ Quality Management/QI Committee Charter ▪ Entire Year of the most recent QI Committee Meeting Minutes, Membership List and Attendance Sheets ▪ Organizational Chart ▪ Medical Director Job Description ▪ Copy of medical director's valid and current medical license ▪ Provider Advisory Committee(PAC)/Medical Advisory Committee (MAC) membership lists ▪ Entire Year of the most recent PAC/MAC Charter, Meeting Minutes and Attendance Sheets ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Forms showing attestations regarding ability to treat enrollees with special needs

		b. The development, interpretation and implementation of MLTSS policies and procedures to guide and support the provision of MLTSS to enrollees; c. Oversight of physical, behavioral and MLTSS provider recruitment activities; d. Reviewing all providers' applications and making recommendations to those with contracting authority regarding credentialing and reappointing all providers prior to the providers' contracting (or renewal of contract) with the Contractor's plan; e. Continuing surveillance of the performance of providers in their provision of health care to enrollees; f. Administration of all clinical activities of the Contractor; g. Continuous assessment and improvement of the quality of care and services provided to enrollees; h. Serving as Chairperson of Quality Management Committee; [Note: the medical director may designate another physician to serve as chairperson with prior approval from DMAHS.] i. Oversight of all provider education, in-service training and orientation; j. Assuring that adequate staff and resources are available for the provision of medical, behavioral and MLTSS services to enrollees; k. Coordinating with other Medical Directors, as necessary, to ensure integrated and coordinated medical, behavioral, dental and MLTSS services (formal and informal) for MLTSS Members; and l. The review and approval of studies and responses to DMAHS concerning QM matters. **4.7.2.A.6** The Contractor shall submit on an annual basis to DMAHS and/or the EQRO at the direction of the State, documentation of its ongoing internal quality assurance activities. Such documentation shall include at a minimum: a. Agenda of quality assurance meetings of its medical and service professionals; and b. Attendance sheets with attendee signatures. c. Minutes of all Quality Assurance meetings, approved and signed.	

		B.4.14.IV **ACTIVE QA COMMITTEE** - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO, including those QA functions regarding MLTSS. This committee or other structure has: **A. regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly. **B. established parameters for operating** - The role, structure and function of the structure/committee are specified. **C. documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions. **D. accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions. **E. membership** - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers, including MLTSS providers whose function is to support the enrollees ability to receive services in the setting of their choice. **B.4.14.V** **QAPI SUPERVISION** - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.	
CS3	4.6.2.BB	**4.6.2.BB** **Provider Advisory Committee (PAC)** The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long term care needs and special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year.	▪ QI Program Description ▪ QI/PAC Charter ▪ Entire Year of the most recent PAC Meeting Minutes, Agendas, membership Lists and Attendance Sheets ▪ Reports showing the percentage of Medicaid enrollees served by providers on the committee ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Provider Directory ▪ Provider Database File ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agendas, and Sign-In Sheets
CS4	4.6.2.BB.1	**4.6.2.BB.1**	▪ Dental Affairs Advisory Subcommittee Charter

		The Contractor shall have a Dental Affairs Advisory Subcommittee to give participating dental providers the opportunity to provide input to the MCO in improving dental performance rates based on CMS-416 data and quality of care.	▪ Entire Year of the most recent Dental Affairs Advisory Subcommittee Meeting Minutes, Agendas, and Attendance Sheets ▪ Dental Affairs Advisory Subcommittee Membership List ▪ Entire Year of the most recent PAC Meeting Minutes ▪ Entire Year of the most recent QI Meeting Minutes ▪ Dental initiatives including outcomes
CS5	4.6.1.C.9	**4.6.1.C.9** **Dental Director** The Contractor shall have on staff a full time (minimum 40 hours per week) Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery or a Doctor of Dental Medicine. The Dental Director must have practiced in New Jersey and shall be responsible for: a. The development, implementation and interpretation of clinical criteria and dental policies and procedures to guide and support the provision of dental care by both the Contractor and its subcontractor (if applicable) in accordance with NJFC regulations; b. Oversight or shared oversight of dental provider recruitment, credentialing and re-credentialing activities with emphasis placed on the recruitment and retention of providers who treat members with special needs and/or disabilities; c. Monitoring of the dental network, including review of all dental applications, to ensure network adequacy standards are met, including but not limited to provider ratios, in-county minimum, office hour minimums, and geographical accessibility standards, as set for in the Contract; d. Surveillance of the performance of providers (including the providers of their subcontractor), in their provision of dental care to enrollees. This includes but is not limited to; identifying and addressing quality of care, continuity of care (to include orthodontic treatment and other multi-visit procedures), member outreach for missing EPSDT dental periodicity services and fraud, waste and abuse; e. Administration and oversight of all dental activities of the Contractor and review all written information and materials provided to the public, Members and Providers for contract compliance;	▪ Dental Service Coordinator Job Description ▪ Organizational Chart ▪ Entire Year of the most recent Dental Advisory Meeting Minutes, Agenda, and Attendance Sheets

		f. Where applicable, monitors IDD, SHCN and pediatric member assignment for appropriateness; g. Continuous assessment and improvement of utilization of dental services and the quality of dental care provided to Members. This shall apply to the EPSDT requirement for the first year dental visit, establishing a dental home by the age of two (2), increased utilization for pediatric preventive dental services by PCDs and oral health services by non-dental providers/medical personnel for members through age three (3); h. Serving on the Contractor's Quality Management Committee; serving on the Contractor's credentialing committee and/or the subcontractor's credentialing committee when applicable; i. Oversight of the orientation, education, and in-service training provided to network providers to include collection of attestations for fluoride varnish application by medical personnel; j. Reviewing dental consultants for inter-rater reliability and monitor consultants' activities quarterly for compliance; k. Assuring that adequate Contractor staff and resources are available for prompt response to member and provider concerns, State referrals, requests for various deliverables and the appeals process; l. The review and approval of studies, reports and responses to DMAHS concerning utilization and Quality matters; m. Representing the Contractor at Medicaid Fair Hearings and IUROs; n. Representing the Contractor at meetings of the Dental Advisory Council of DMAHS; o. If the Contractor contracts with a dental subcontractor, the Contractor's Dental Director shall provide direction and monitor its performance to ensure contract compliance and continuous quality improvement; ensure that decisions are made in a clinically-appropriate and timely manner based on the current clinical criteria policy; review all written information and materials provided to the public, Members and Providers to ensure the subcontractor complies with NJ FamilyCare policies, New Jersey State Board of Dentistry regulations, and that the Contractor's name is prominently displayed on all subcontractor materials;	

		p. Verification on a monthly basis that dental providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs.	
CS6	4.6.2.Z	**4.6.2.Z** **Community/Health Education Advisory Committee** The Contractor shall establish and maintain a community advisory committee, consisting of Members being served by the Contractor, including MLTSS Members, authorized persons, individuals and providers with knowledge of and experience with serving elderly people, people with disabilities or people eligible for MLTSS; and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year(s).	▪ Community/Health Education Advisory Committee (HEAC) Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the Community/Health Education Advisory Committee activities ▪ QI Program Description
CS7	B.4.14.X.H	**B.4.14.X.H** The MCO shall ensure an opportunity is provided for Members to offer suggestions for changes in policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ HEAC Charter ▪ Entire Year of the most recent HEAC Meeting Minutes, Attendance List, Agendas ▪ Entire Year of the most recent Committee Meeting Minutes as appropriate ▪ Member Handbook
CS8***	4.6.2.AA	**4.6.2.AA** MLTSS Consumer Advisory Committee. The Contractor shall establish an MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, a representative group of MLTSS population participants, or individuals representing those enrollees, case managers, and others, and will address issues related to MLTSS. Contractor shall forward results and follow-up items to DMAHS on a quarterly basis.	▪ MLTSS CAC Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the MLTSS CAC activities ▪ QI Program Description
CS9*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion

		notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Programs for the Elderly and Disabled			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6.2.R 4.6.2.R.1 4.6.2.R.1.g	**4.6.2.R** **Care for Persons with Disabilities and the Elderly** (Defined as SSI-Aged and New Jersey Care – Aged enrollees and SSI and New Jersey Care enrollees with disabilities). The Contractor shall have the system capability to track and report on each population separately. **4.6.2.R.1** The Contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for NJ FamilyCare elderly enrollees and enrollees with disabilities, and MLTSS Members. **4.6.2.R.1.g** The Contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit (See Article 4.7). The Quality Department shall:	
ED1	4.6.2.R.1.a	**4.6.2.R.1.a** Oversee quality of life indicators, such as: i. Degree of personal autonomy; ii. Provision of services and supports that assist people in exercising medical and social choices; iii. Self-direction of care to the greatest extent appropriate; iv. Maximum use of natural support networks; and v. Maintenance of optimal level of functioning.	▪ QI Work Plan ▪ Adult and Pediatric Complex Needs Assessment (CNA) ▪ New Jersey Choice Assessment ▪ Health Risk Assessment (HRA) ▪ Quality Improvement Program Description ▪ Care Management Program Description ▪ Care of Persons with Disabilities and the Elderly Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Care Management examples for the specific population
ED2	4.6.2.R.1.b	**4.6.2.R.1.b** Review persistent or significant grievances from elderly enrollees, enrollees with disabilities, and MLTSS Members or their authorized person, identified through Contractors' grievance procedures and through external oversight;	▪ Policies and procedures addressing the following: ▪ Grievances ▪ Special Needs Enrollee Grievance Summary by category and analysis of findings ▪ Entire Year of the most recent QI Committee Meeting Minutes

			▪ Enrollee Appeals Summary and Analysis
ED3	4.6.2.R.1.c	**4.6.2.R.1.c** Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Policies and Procedures addressing the following: ➢ Care Management of the Elderly and the Disabled ➢ Review and Revision of Policies and Procedures ▪ Quality of Care/Service Policy and Procedure ▪ QI Program Description ▪ Clinical Practice Guidelines
ED4	4.6.2.R.1.d	**4.6.2.R.1.d** Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Disabled and Elderly quarterly, semiannual or annual grievance summary and analysis ▪ Over/Under Utilization of Services Report ▪ Quality of Care/Services Reports ▪ Drug Utilization Review Report and Analysis ▪ Quality Outcomes Report and Analysis ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.1.e	**4.6.2.R.1.e** **Care for Persons with Disabilities and the Elderly** Develop written procedures and protocols for at least the following:	
ED5	4.6.2.R.1.e.i	**4.6.2.R.1.e.i** Assessing the quality of complex health care/Care Management;	▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Adult CNA Form ▪ HRA ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED6	4.6.2.R.1.e.ii	**4.6.2.R.1.e.ii** Ensuring Contractor compliance with the Americans with Disabilities Act (ADA); and	▪ Policies and Procedures addressing the following: ➢ Americans with Disabilities Act Policy ➢ Credentialing/Recredentialing ▪ Provider Manual ▪ Provider Participating Agreement ▪ Provider Office Site Audit Tool ▪ Provider Application ▪ Corrective Action Plans for non-compliant providers

			▪ Examples of provider site visit summaries ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED7	4.6.2.R.1.e.iii	**4.6.2.R.1.e.iii** Instituting effective health and function management protocols for elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the ▪ following: ➢ Care of Persons with DDD and the Elderly and the institution of effective health management protocols ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Health Risk Assessment ▪ Adult CNA Form ▪ New Jersey Choice Assessment ▪ MLTSS Level of Supervision Assessment (CRS-settings) ▪ Treatment Protocols (e.g., Milliman & Robertson® or InterQual®) ▪ Preventive Health Guidelines
ED8	4.6.2.R.1.f	**4.6.2.R.1.f** Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the following: ➢ Care of Persons with DDD and the Elderly ▪ Quality Outcomes Report and Analysis ▪ QI Program Description ▪ Provider Manual ▪ QI Program Evaluation ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.2	**4.6.2.R.2** **Initiatives for Aged, including MLTSS Members.** The Contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:	
ED9	4.6.2.R.2.a	**4.6.2.R.2.a** The Contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:	▪ Pneumococcal Vaccination and Influenza Immunizations Program Description ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines

			▪ Specialty Programs developed to address the needs of the elderly ▪ State Program Approval ▪ Provider Manual ▪ Provider Newsletters ▪ Pneumococcal Vaccination and Influenza Immunization Initiatives
ED10	4.6.2.R.2.a.i	**4.6.2.R.2.a.i** Development, distribution, and measurement of PCP compliance with practice guidelines;	▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Provider Specific HEDIS® Results ▪ Provider Profiling Program ▪ Provider Profiling Reports ▪ Physician Practice Overview Reports ▪ Follow-up on non-compliant providers ▪ Screen Prints
ED11	4.6.2.R.2.a.ii	**4.6.2.R.2.a.ii** Educational outreach for enrollees and practitioners;	▪ Pneumococcal vaccination and Influenza Immunizations Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives developed to address deficiencies including outcomes
ED12	4.6.2.R.2.a.iii	**4.6.2.R.2.a.iii** Access for ambulatory and homebound enrollees;	▪ Policies and Procedures addressing the following: ➢ Access to pneumococcal vaccines and influenza immunizations for homebound enrollees ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Member Handbook ▪ Screen Prints of the Enrollee Website ▪ Health Risk Assessment ▪ 3 Blinded Care Management Records
ED13	4.6.2.R.2.b	**4.6.2.R.2.b** The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, mammography and prostate cancer screening. The Program shall include the following components:	▪ Preventive Cancer Screening Program Description ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ HEDIS® Results and Analysis

			▪ Enrollee Preventive Health Screenings Reports including barrier analysis, initiatives developed to address deficiencies and outcomes ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ Provider Manual ▪ Provider Newsletters
ED14	4.6.2.R.2.b.i	**4.6.2.R.2.b.i** Measurement of provider compliance with performance standards;	▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints
ED15	4.6.2.R.2.b.ii	**4.6.2.R.2.b.ii** Education outreach for both enrollees and practitioners regarding preventive cancer screening services;	▪ Preventive Cancer Screening Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED16	4.6.2.R.2.b.iii	**4.6.2.R.2.b.iii** Breast cancer screening in accordance with Centers for Disease Control (CDC) recommendations;	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED17	4.6.2.R.2.b.iv	**4.6.2.R.2.b.iv** Prostate cancer screening in accordance with CDC recommendations.	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED18	4.6.2.R.2.b.v	**4.6.2.R.2.b.v**	▪ Provider Manual

		Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Records Audit ▪ Medical Record Review Program ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider medical review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED19	4.6.2.R.2.c	**4.6.2.R.2.c** The Contractor shall develop specific programs for the care of enrollees identified with congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, hypertension (HTN), and depression. The program shall include the following components:	▪ Disease Management Program Descriptions for the following: ➢ Congestive heart failure (CHF) ➢ Chronic obstructive pulmonary disease (COPD) ➢ Diabetes ➢ Hypertension (HTN) ➢ Depression ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ CHF, COPD, Diabetes, HTN and Depression Initiatives Including Outcomes ▪ Educational Materials
ED20	4.6.2.R.2.c.i	**4.6.2.R.2.c.i** Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ 3 Blinded Examples of Enrollee Care Plans ▪ Screen Prints
ED21	4.6.2.R.2.c.ii	**4.6.2.R.2.c.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Disease Management/Complex Case Management Annual Outcomes Report for the Specified Populations ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Profiling Program Description ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports

			▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED22	4.6.2.R.2.c.iii	**4.6.2.R.2.c.iii** Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;	▪ Examples of educational materials for enrollee and caregivers ▪ Disease Management Programs for specified disease states ▪ Educational Program Evaluations
ED23	4.6.2.R.2.c.iv	**4.6.2.R.2.c.iv** Educational materials for clinical providers in the best practices of managing the disease; and	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED24	4.6.2.R.2.c.v	**4.6.2.R.2.c.v** Evaluation of effectiveness of each program by measuring outcomes of care.	▪ Disease Management Program ▪ Disease Specific Outcomes Report ▪ HEDIS® Results and Analysis ▪ Annual Disease Management Program Evaluation ▪ QI Evaluation ▪ Outcomes Report ▪ Disease Specific Program Evaluations
ED25	4.6.2.R.2.d	**4.6.2.R.2.d** The Contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:	▪ Policies and Procedures addressing the following: ➢ Care of Persons with cognitive impairments and the elderly ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Annual Outcomes Report ▪ Annual Outcomes Analysis ▪ HRA
ED26	4.6.2.R.2.d.i	**4.6.2.R.2.d.i** Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description Care Management of enrollees with cognitive impairments ▪ 3 Blinded Examples of Enrollee Care Plans
ED27	4.6.2.R.2.d.ii	**4.6.2.R.2.d.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Outcome Reports ▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description

			▪ QI Work Plan ▪ QI Evaluation ▪ Disease Management/Complex Care Management Annual Outcomes Report for the Specified Population ▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED28	4.6.2.R.2.d.iii	**4.6.2.R.2.d.iii** Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and	▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Examples of Educational Material for Enrollee and Caregivers ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Case Examples
ED29	4.6.2.R.2.d.iv	**4.6.2.R.2.d.iv** Educational materials for clinical providers in the best practices of managing cognitive impairments.	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED30*	4.6.2.R.2.e	**4.6.2.R.2.e** **Initiatives to Prevent Long-Term Institutionalization (LTI)** Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions. This program shall include, but is not limited to, the following:	▪ LTI Program Description ▪ LTI Initiatives Including Outcomes
ED31*	4.6.2.R.2.e.i	**4.6.2.R.2.e.i** Identification of medical and social conditions that indicate risk of being institutionalized;	▪ Desk Top Procedures ▪ CNA ▪ Utilization Management Process Flowcharts ▪ Risk Assessments ▪ Redacted cases of Identification of At-risk Enrollees
ED32*	4.6.2.R.2.e.ii	**4.6.2.R.2.e.ii** Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;	▪ Care Management Program Description ▪ Community Based Care Management Description

			▪ Utilization Management Program Description ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Utilization Management cases ▪ Examples of Care Plans ▪ Provider Communications ▪ Desk-Top Procedures ▪ Utilization Management/Case Management Notes ▪ Provider Programs addressing the prevention of LTI
ED33*	4.6.2.R.2.e.iii	**4.6.2.R.2.e.iii** Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Protocols addressing preventive services for at-risk enrollees ▪ CNA ▪ HRA ▪ UM Cases ▪ Blinded Enrollee Care Plans ▪ Prevention of LTI Desk-Top Procedures
ED34*	4.6.2.R.2.e.iv	**4.6.2.R.2.e.iv** Provision of home/community services covered by the Contractor.	▪ Policies and Procedures addressing the following: ➢ Home Care and Private Duty Nursing ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Referral Desk-Top Procedure ▪ CNA ▪ Blinded Enrollee Care Plan ▪ Blinded Case File
ED35	4.6.2.R.2.f	**4.6.2.R.2.f** **Abuse and Neglect Identification Initiative** Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Care Management ▪ Risk Assessments ▪ CNA ▪ Employee Training ▪ Blinded Case Example showing suspected abuse and neglect ▪ Care Management Program Description

			▪ Community Based Care Management Description ▪ MLTSS Member training on Abuse/Neglect identification and reporting.
ED36	4.6.2.R.2.f.i	**4.6.2.R.2.f.i** Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Diagnostic tools for identifying enrollee abuse and neglect ▪ Customer Service Script ▪ Customer Service Education related to potential abuse and neglect ▪ Data Triggers
ED37	4.6.2.R.2.f.ii	**4.6.2.R.2.f.ii** Protocols and interventions to treat abuse and neglect of enrollees, including ongoing evaluation of the effectiveness of these protocols and interventions; and	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Abuse and Neglect Protocols ▪ Case Management file of an enrollee that has had confirmed abuse and neglect ▪ Descriptions of interventions for treating abuse and neglect ▪ Program Evaluation ▪ Care Management Program Description ▪ Community Based Care Management Description
ED38	4.6.2.R.2.f.iii 4.6.2.R.2.f.iv	**4.6.2.R.2.f.iii** Coordination of these efforts through the PCP. **4.6.2.R.2.f.iv** Reporting of MLTSS-related critical incidents in accordance with Article 9.	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ Case example of confirmed abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Educational Materials ▪ CI reporting procedures and reports
Sub-heading	4.6.2.S	**4.6.2.S** For the elderly, enrollees with disabilities, and MLTSS Members, the Contractor shall monitor, evaluate and report on Member outcomes at least annually. The Contractor shall have the system capability to track and report on each population separately, and make available the results of the	

		evaluation to DMAHS during the annual assessment audits. (See Article 4.7). The Contractor shall include of the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and Care Management, and other activities as indicated:	
ED39*	4.6.2.S.1	**4.6.2.S.1** Aspiration pneumonia	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Aspiration pneumonia Initiatives Including Outcomes
ED40*	4.6.2.S.2	**4.6.2.S.2** Injuries, fractures, and contusions	▪ Outcome Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Injuries, fractures, and contusions Initiatives Including Outcomes
ED41*	4.6.2.S.3	**4.6.2.S.3** Decubiti	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Decubiti Initiatives Including Outcomes
ED42*	4.6.2.S.4	**4.6.2.S.4** Seizure management	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Seizure Management Initiatives Including Outcomes
ED43**	9.7.5	**9.7.5** **Nursing Facility Diversion**	▪ State approved Nursing Facility Diversion program which includes:

		A. The Contractor shall develop and implement a nursing facility diversion process that shall be approved by the State and CMS prior to implementation. The nursing facility diversion plan shall include, but not be limited to the following provisions: 1. Comprehensive clinical assessment process that identifies Members' health care and service needs; 2. Options Counseling process that ensures Members are educated on the full range of LTSS and offered a choice of care (institutional/home and community based services) and option to choose MLTSS or PACE (if available); and 3. A person-centered Plan of Care (POC) approach is implemented; 4. Monitoring hospitalizations, short term NF stays and identifying issues and strategies to improve diversion outcomes, and B. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary. The Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified below: 1. MLTSS members who request admission to a nursing facility for custodial care; 2. MLTSS members residing in the community who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services; 3. MLTSS members that the Contractor becomes aware are admitted to an inpatient hospital and who are not residents of a nursing facility.	▪ Identification of members for inclusion in the program ▪ Clinical assessment process ▪ Education to members regarding the process
ED44*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Provider Training and Performance

2022 Element	Contract Reference	Contract Requirement Language	Documentation Examples
PT1	3.7.1.A.1 4.6.2.V 4.6.4.A.3	**3.7.1.A.1** The system shall provide reports to monitor and identify deviations of patterns of treatment from established standards or norms and established	▪ Policies and Procedures addressing the following: ➢ Provider Profiling including panel size requirements

	7.24.D 7.24.E	baselines. These reports shall profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals. **4.6.2.V** **Provider Performance Measures** The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. Data shall be supplied to providers for their management activities. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate: 1. Resource utilization of services, specialty and ancillary services; 2. Clinical performance measures on outcomes of care; 3. Maintenance and preventive services; 4. Enrollee experience and perceptions of service delivery; and 5. Access. **4.6.4.A.3** **Data Collection and Reporting** The plan shall provide for systematic utilization data collection and analysis, including profiling of provider utilization patterns and patient results. The Contractor must use aggregate data to establish utilization patterns, allow for trend analysis, and develop statistical profiles of both individual providers and all network providers. Such data shall be regularly reported to the Contractor management and Contractor providers. The plan shall also provide for interpretation of the data to providers. **7.24.D** The Contractor shall provide its primary care practitioners with quarterly utilization data within forty-five (45) days of the end of the program quarter comparing the average medical care utilization data of their enrollees to the average medical care utilization data of other managed care enrollees. These data shall include, but not be limited to, utilization information on enrollee encounters with PCPs, children who have not received an EPSDT examination or a blood lead screening, specialty claims, prescriptions, inpatient stays, and emergency room use. **7.24.E** The Contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians	▪ Provider Profiling Program Description ▪ Most recent Provider Profile Results ▪ Cover letter for Provider Profiling ▪ Utilization of Special Services Report (MRI, CT SCAN, etc.) ▪ Various data including ER, Drug and Dental Services Utilization ▪ HEDIS® Results and Analysis ▪ EPSDT Monitoring ▪ Outcomes Reports ▪ CAHPS® Reports ▪ Member Grievance Analysis Reports ▪ Access Reports ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)

		and other health care practitioners participate. The Contractor shall review and assess data using statistically valid sampling techniques including, but not limited to, the following: Primary care practitioner audits; specialty audits; inpatient mortality audits; quality of care and provider performance assessments; quality assurance referrals; credentialing and recredentialing; verification of encounter reporting rates; quality assurance committee and subcommittee meeting agendas and minutes; enrollee grievances, appeals, and follow-up actions; providers identified for trending and sanctioning, including providers with low blood lead screening rates; special quality assurance studies or projects; prospective, concurrent, and retrospective utilization reviews of inpatient hospital stays; and denials of off-formulary drug requests.	
PT2	4.6.1.C.4	**4.6.1.C.4** Medical Record standards shall address **Medical, Behavioral, Dental**, and **MLTSS** records. Records shall also contain notation of any cultural/linguistic needs of the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Dental Record Documentation Standards ➢ Medical Records Audit ▪ Provider Manual ▪ Medical and Dental Record Review Programs ▪ Medical and Dental Record Review Audit Tools ▪ Most recent Medical and Dental Record Review Audit Findings ▪ Provider medical/dental review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
PT3	4.6.2.K	**4.6.2.K** **Ethical Issues** The Contractor shall comply and monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including, but not limited to: ▪ Advance Directives, ▪ Family Planning services for minors, and ▪ Other issues as identified. The Contractor shall submit a report within thirty (30) days to DMAHS with changes or updates to the policies.	▪ Policies and Procedures addressing the following: ➢ Medical Records Documentation Standards ➢ Treatment of Minors ➢ Medical Records Audit ➢ Advance Directives ➢ Medical Records Standards ▪ Most recent Medical Records Audit findings ▪ Provider Manual ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)

			▪ Initiatives Developed to Address Deficiencies including Outcomes
PT4	4.6.2.N	**4.6.2.N** **Informed Consent** The Contractor is required and shall require all participating providers to comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers. Copies of the forms are included in Section B.4.15 of the Appendices.	▪ Policies and Procedures addressing the following: ➢ Informed Consent ➢ Informed Consent for hysterectomies and sterilizations ▪ Examples of Consent Forms with instructions ▪ Provider Manual ▪ Monitoring Procedures ▪ Claims Denial Logs ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT5*	4.7.2.E	**4.7.2.E** The Contractor shall produce reports of all PCPs in its network (regardless of panel size), who are treating children under 21 years old, that provide information to the PCPs of underutilization or no utilization of their enrollee panel Members as compared to Early Periodic Screening and Diagnostic Testing (EPSDT) utilization requirements.	▪ Provider Profiling Program ▪ Provider Profiling Procedures ▪ Provider Profiles ▪ EPSDT Monitoring ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT6	6.3.A	**6.3.A** **Provider Education and Training** A. Initial Training. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants. Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups.	▪ Policies and Procedures addressing the following: ➢ Provider Education ▪ Provider Training Overview/Program ▪ Provider Toolkit/Training Curriculum ▪ Signed Acknowledgement of Training Forms ▪ Training Attendance Forms or Learning Management System (LMS) attendance reports ▪ Provider Manual ▪ Dental Services Provider Manual ▪ Medical and Dental Provider Welcome Letters ▪ PowerPoint Presentations ▪ Tracking Logs for provider trainings
PT7	6.3.B	**6.3.B** **Ongoing Training** The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual

		with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor.	▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT8*	B.4.14.XII.A Appendix	**B.4.14.XII.A** **Accessibility and Availability of Medical Records** 1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof. 2. Records are available to providers at each encounter. 3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical and service records.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Record Accessibility and Availability ▪ Provider Participation Agreement ▪ Provider Manual ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider Review Results Notification Letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)
PT9	B.4.14.X.K Appendix	**B.4.14.X.K** The MCO acts to ensure that the confidentiality of specified patient information and records is protected. 1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records. 2. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas. 3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization. 4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless: a. it is required by law; b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health	▪ Policies and procedure addressing the following: ➢ Privacy and Confidentiality ➢ Medical Record Storage ➢ Medical Record Standards ➢ Medical Record Accessibility and Availability ▪ Compliance Program Description ▪ Provider Manual ▪ Provider Agreement ▪ Medical Record Audit Tool ▪ Most recent Medical Record Review Audit findings ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Provider review results notification letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)

		care entities, or to coordinate insurance or other matters pertaining to payment; c. it is necessary in compelling circumstances to protect the health or safety of an individual. 5. Any release of information in response to a court order is reported to the patient in a timely manner. 6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.	
PT10**	6.3.C	**6.3.C** MLTSS Provider Education and Training 1. The Contractor shall work with the State and other contracted MCOs to establish and conduct universal MLTSS provider training. 2. The training curriculum shall include written materials for nursing facilities, assisted living and HCBS providers. This standardized curriculum shall address at a minimum the credentialing processes, service authorizations, continuity of care, community resources, options counseling, claims processes, cultural competency and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board. 3. The Contractor shall conduct provider training with all new MLTSS providers and on an ongoing basis as needed.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT11*	4.7.4	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Satisfaction

2022 Element	Contract Reference	Contract Requirement Language	Documentation Examples
S1*	4.6.2.W	**4.6.2.W** **Member Satisfaction** The State will assess Member satisfaction of Contractor services via the Contractor's adult and child Medicaid Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey version 5.1H, or the version required	▪ MCO CAHPS® analysis including improvement actions ▪ State communications regarding results

		for NCQA accreditation, including supplemental questions to be done at the discretion of the State. The Contractor must administer the entire adult and child CAHPS surveys without amendment and follow the instructions contained in the NCQA Specifications for Survey Measures for the current HEDIS year. The Contractor shall fully cooperate with its independent survey administrator such that the MCO's final, analyzed survey results shall be available to the State and/or its designee by June 15th of each contract year.	
S2	4.6.2.W	**4.6.2.W** On an annual basis, the Contractor must also ensure that its independent survey administrator submits the final CAHPS raw data to the Agency for Healthcare Research and Quality (AHRQ), and/or entity responsible for maintaining the national CAHPS database and authorizes its use for State level reporting. Contractors shall submit a Workplan by August 15th, or other time period as requested by the DMAHS. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where consumer satisfaction is potentially below quality standards. At the State's discretion, a CAP may be required. The Contractor shall submit corrective actions in a format approved by the State, to identify leading sources of enrollee dissatisfaction, specify additional measurement or intervention efforts developed to address enrollee dissatisfaction, and a timeline indicating when such activities will be completed. Upon the State's request, a status report on the additional measurement or intervention efforts shall be submitted by the Contractor to the State by a date specified by DMAHS. Additionally, for any CAHPS Survey or other member satisfaction survey conducted by the State and/or its designee, on behalf of the State, the Contractor and/or its vendor shall fully cooperate with the State and/or its designee, and make available all survey related data in a timely manner. Results will be shared with the MCOs, and at the discretion of the State, a Workplan may be requested for areas of enrollee dissatisfaction. If the Contractor conducts a Member satisfaction survey of its own, it shall send to DMAHS the results of the survey..	▪ Corrective Action Plans ▪ Acknowledgement of receipt of submitted corrective action plans from the State ▪ Monitoring of corrective action ▪ Outcome Reports ▪ Quality Improvement Work Plan
S3	B.4.14.X.M Appendix	**B.4.14.X.M** **Assessment of Member Satisfaction** If the organization conducts periodic surveys of Member satisfaction with its services, including MLTSS, the following must be included in the surveys.	Enrollee Satisfaction Survey Results performed by the MCO including those for targeted populations

		1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors, specialists, MLTSS providers who are trained and experienced in treating people with disabilities. 2. The surveys assess at least a sample of: a. all Medicaid Members; b. Medicaid Member requests to change practitioners and/or facilities; and c. disenrollment by Medicaid Members; and d. enrollees receiving MLTSS. 3. As a result of the surveys, the organization: a. identifies and investigates sources of dissatisfaction; b. outlines action steps to follow-up on the findings; and c. informs practitioners and providers of assessment results. 4. The organization reevaluates the effects of the above activities.	
S4*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
S5*	5.16.1.X.1	**5.16.1.X.1** **Periodic Survey of Enrollees** The Contractor shall quarterly survey new enrollees, in person, by phone, or other means, on a random basis to verify the enrollees' understanding of the Contractor's procedures and services availability. Results of the surveys shall be made available to DMAHS and/or the EQRO at the direction of the State for review on request at regularly scheduled on site visits.	▪ Results of surveys performed by the MCOs. ▪ Quarterly breakout of number of surveys fielded.
Enrollee Rights and Responsibilities			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
ER1	B.4.14.X.A	**B.4.14.X.A**	▪ Policies and Procedures addressing the following:

	B.4.14.X.C Appendices	**Written Policy on Enrollee Rights** The MCO shall have a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of Members: **<u>Enrollee Rights</u>** 1. to be treated with respect, dignity, and need for privacy; 2. to be provided with information about the organization, its services, the practitioners providing care, and Members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed; 3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners; 4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence; 5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers; 6. to formulate advance directives; 7. to have access to his/her medical records in accordance with applicable Federal and State laws; 8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect; 9. to be free of hazardous procedures; 10. to receive information on available treatment options or alternative courses of care; 11. to refuse treatment and be informed of the consequences of such refusal; and 12. to have services provided that promote a meaningful quality of life and autonomy for Members, independent living in Members' homes and other community settings as long as medically and socially feasible, and preservation and support of Members' natural support systems. **B.4.14.X.C** **Written Policy on Enrollee Responsibilities** The MCO shall have a written policy that addressees Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for:	➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		1. providing, to the extent possible, information needed by professional staff in caring for the Member; and 2. following instructions and guidelines given by those providing health care services.	
ER2	B.4.14.X.E Appendix	**B.4.14.X.E** **Communication of policies to providers and organization staff** The MCO shall assure a copy of the organization's policies on Members' rights and responsibilities is provided to all participating providers annually. The MCO must monitor and promote compliance with the policies by the Contractor's staff and affiliated providers.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO provider Website Screen Prints ▪ Monitoring Procedures
ER3*	B.4.14.X.F Appendix	**B.4.14.X.F** **Communication of policies to enrollees/Members** Upon enrollment and annually thereafter, Members are provided a written statement that includes information on the following: 1. rights and responsibilities of Members including the specific informational requirements of this section; 2. benefits and services, including MLTSS, included and excluded as a condition of membership, and how to obtain them, including a description of: a. procedures for obtaining services, including MLTSS, including authorization requirements; b. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; c. procedures for obtaining services covered by the Medicaid fee-for-service program; d. the procedures for obtaining out-of-area coverage; and e. policies on referrals for specialty and ancillary care. 3. provisions for after-hours and emergency coverage and for MLTSS Members provision of key contact information such as the emergency after hours number with immediate access to a Contractor's staff Member who has access to the Member's plan of care and who can make immediate service authorizations and perform care coordination functions; 4. the organization's policy and procedures on referrals for specialty care, ancillary services and MLTSS; 5. charges to Members, if applicable, including: a) policy on payment of charges; b) co-payments, patient pay liability and fees for which the Member is responsible; and c) what to do if a Member receives a bill for services or is non-compliant with payment of co-payments, patient pay liabilities or other fees.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ Website Screen Prints ▪ Member Letters

		6. procedures for notifying those Members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers. 7. procedures for appealing decisions adversely affecting the Member's coverage, benefits, or relationship to the organization; 8. procedures for changing providers; 9. procedures for disenrollment; and 10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.	
ER4	B.4.14.X.J Appendix	**B.4.14.X.J** The MCO has written information for Members. 1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood at a 5th grade reading level using a font size no smaller than 12 point. All written materials for potential enrollees and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point. 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.	▪ Enrollee educational materials in different languages ▪ Approval letters from the State on enrollee educational literature ▪ Population Study Results ▪ Written information in various languages ▪ Readability Scores
ER5	B.4.14.X.L Appendix	**B.4.14.X.L** **Treatment of Minors and Individuals with Disabilities** The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.	▪ Policies and Procedures addressing the following: ➢ Treatment of Minors and Individuals with Disabilities ▪ Program Descriptions for the following: ➢ Care Management ➢ Quality Improvement ➢ Utilization Management
ER6**	B.4.14.X.B B.4.14.X.D Appendices	**B.4.14.X.B** Written policy on MLTSS Member rights - The organization has a written policy that recognizes the following rights of MLTSS Members: 1. To request and receive information on choice of services available; 2. Have access to and choice of qualified service providers; 3. Be informed of your rights prior to receiving chosen and approved services; 4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability;	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		5. Have access to appropriate services that support your health and welfare; 6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made; 7. To make decisions concerning your care needs; 8. Participate in the development of and changes to the Plan of Care; 9. Request changes in services at any time, including add, increase, decrease or discontinue; 10. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under the Plan of Care; 11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers; 12. Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings; 13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility; 14. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment. 15. Have your health plan protect and promote your ability to exercise all rights identified in this document. 16. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian. **B.4.14.X.D** Written policy on MLTSS Member responsibilities - The organization has a written policy that addressees Members' responsibility for cooperating with those providing services. This written policy addresses Members' responsibility for: 1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care; 2. Understand your health care needs and work with your Care Manager to develop or change goals and services; 3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services; 4. Ask questions when additional understanding is needed; 5. Understand the risks associated with your decisions about care;	

		6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager; 7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and 8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).	
ER7**	4.6.1.B.2	**4.6.1.B.2** Provide for MLTSS to allow an individual to maintain themselves in the least restrictive, most integrated setting of their choice, to the extent possible. Such service provision shall promote the enrollee's ability to age in place through coordination of formal and informal supports to address the assessed needs of the individual.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ MLTSS Member Handbook ▪ Care Management
ER8*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Credentialing and Re-credentialing

2022 Element	Contract Reference	Contract Requirement Language	Documentation Examples
CR1	**4.8.5.C**	**4.8.5.C** C. The Contractor shall collect and maintain, as part of its credentialing process, through special survey process, or other means information from licensed practitioners including pediatricians and pediatric subspecialists about the nature and extent of their experience in serving children with special health care needs including developmental disabilities.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Process for collecting data on a provider's experience in treating children with special healthcare needs including how it maintains and updates the information ▪ Survey for collecting provider experience in treating children with special healthcare needs including examples ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness

CR2*	4.6.1.C.5	**4.6.1.C.5** Provider Credentialing. New Jersey requires a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Before any provider/subcontractor may become part of the Contractor's network, that provider/subcontractor shall be credentialed by the Contractor. The Contractor must comply with N.J.A.C. 11:24C-1 et seq. and Standard IX of New Jersey QAPI Standards, (Section B.4.14 of the Appendices). Additionally, the Contractor's credentialing procedures shall include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The Contractor shall obtain federal and State lists of suspended/debarred providers from the appropriate agencies and comply with the specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35 and found at B.7.35. The Contractor shall ensure providers comply with N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional. The Contractor's process for credentialing shall include notification to providers of errors in the credentialing application within three (3) business days of receipt. The Contractor's credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Ongoing monitoring of State and federal sanctions and suspensions ▪ File review of provider terminated from MCO due to suspension of licensure to practice by CMS or the State of New Jersey ▪ Monitoring of MLTSS providers for suspension
Sub-heading	B.4.14.IX Appendix	**B.4.14.IX** **Credentialing and Re-credentialing** The QAPI contains the following provisions to determine whether physicians, other health care professionals and other providers of services to the Contractor's enrollees meet all applicable state licensing standards, Contractor participation or credentialing criteria and are qualified to provide the care or services for which they have been contracted. (See Article 3.3.2, 4.6.1, 4.8.5, and 7.4E for additional detail regarding credentialing and recredentialing.)	
CR3	B.4.14.IX.A Appendix	**B.4.14.IX.A** **Written Policies and Procedures** The MCO has, at a minimum, written policies and procedures consistent with NCQA standards and State requirements, to address the following: 1. Types of providers, including organizational providers such as Hospitals, Home Health Agencies, NFs, SCNFs, Free-standing surgical centers, ambulatory care centers, inpatient Behavioral Health providers, and residential care settings, to credential and (re)credential, 2. The verification sources used,	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing

		3. Criteria for (re)credentialing, 4. Process for making (re)credentialing decisions, 5. Process for managing credentialing files that meet established criteria, 6. Process for delegating credentialing activities, 7. Process for ensuring (re)credentialing activity is conducted in a non-discriminatory manner, 8. Process for notifying providers if information collected during the (re)credentialing process substantially varies from information they provided as part of the (re)credential process, 9. Process for ensuring providers are notified of the (re)credentialing decision within 60 days of the Committee's decision, 10. Medical Director or other designated physician's direct responsibility and participation in the credentialing program, 11. Process for ensuring confidentiality of information obtained in the (re)credentialing process, except as otherwise provided by law, 12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including education, training, board certification and specialty and 13. Process for ensuring that organizational and non-traditional providers are: • In good standing with State and Federal regulatory bodies • Reviewed and approved by a recognized accrediting body, based on requirements outlined in the MLTSS Services Dictionary found in Appendix B.9.0.	
CR4	B.4.14.IX.B Appendix	**B.4.14.IX.B** **Oversight by Governing Body** The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Quality Improvement Program Description ▪ Credentialing/Re-credentialing Committee Charter ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing process including timeliness
CR5	B.4.14.IX.C Appendix	**B.4.14.IX.C** **Credentialing Entity** The plan shall designate a credentialing committee or other peer review body that includes participating providers from the Contractor's network, which makes recommendations regarding credentialing decisions.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing/Re-credentialing Committee Charter

			▪ Entire Year of the most recent Credentialing/ Re-credentialing Committee Meeting Minutes
CR6	B.4.14.IX.D Appendix	**B.4.14.IX.D** **Scope** The plan identifies those providers who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, behavioral health clinicians, facilities and providers of MLTSS included in the Contractor's literature for Members, as an indication of those providers whose service to Members is contracted or anticipated.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing Committee Charter
CR7	B.4.14.IX.E Appendix	**B.4.14.IX.E** **Process** The initial credentialing process obtains and reviews verification of the following information, at a minimum: 1. the provider holds a current valid license to practice; 2. a dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it; 3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable; 4. work history; 5. professional liability claims history; 6. good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.) 7. the providers hold current, adequate malpractice insurance according to the plan's policy; 8. any revocation or suspension of a State license or DEA number; 9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and 10. any censure by the State or County Medical Association. 11. The organization requests information on the provider from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate licensing board, depending on the provider type. 12. The application process includes a statement by the applicant regarding: a. any physical or mental health problems that may affect current ability to provide health care; b. any history of chemical dependency/ substance use disorder; c. history of loss of license and/or felony convictions;	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing Process ▪ Credentialing Desk-Top Procedure ▪ Credentialing Application ▪ Practitioner Office Site Audit Tool ▪ Regulatory and Accreditation Verification Source Table ▪ Documentation showing monitoring of the credentialing timeliness

		d. history of loss or limitation of hospital privileges or disciplinary activity; and e. an attestation to correctness/ completeness of the applications. This information should be used to evaluate the practitioner's current ability to practice. 13. There is an attestation from each potential primary care provider's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.	
CR8	B.4.14.IX.F Appendix	**B.4.14.IX.F** **Re-credentialing** The MCO shall have a process for the periodic re-verification of credentials (re-credentialing, reappointment, or recertification) described in the organization's policies and procedures. 1. There is evidence that the procedure is implemented at least every three years or more frequently, as necessary, to be in accordance with the providers' licensing requirements. 2. The Contractor shall develop and implement a mechanism for monitoring of critical incident events and grievances related to the care and/or services received that identified trends and determine a threshold at which an off-cycle re-credentialing event would be triggered. 3. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all providers, to decide whether to renew the participating provider agreement. At a minimum, the re-credentialing, recertification or reappointment process is organized to verify current standing on items listed in "E-1" through "E-7" above and item "E-12" as well. 4. The re-credentialing, recertification or reappointment process also includes review of data from: a. Member grievances; b. results of quality reviews; c. performance indicators; d. utilization management; e. critical incidents; and f. re-verifications of hospital privileges and current licensure.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Re-credentialing Process ▪ Re-credentialing Desk Top Procedures ▪ Documentation showing monitoring of re-credentialing timeliness ➢ Ongoing monitoring of critical incidents and grievances and process to trigger off-cycle recredentialing Practitioner-Specific: ➢ Member Grievance Reports ➢ Quality of Care Concerns ➢ Performance Indicators ➢ Utilization Management ➢ Member Satisfaction ➢ Critical incident report monitoring
CR9**	4.6.1.C.7	**4.6.1.C.7** For MLTSS providers the Contractor shall: a. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing of MLTSS providers

		requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members. c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members. i. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the Criminal History Record Information (CHRI) during credentialing process. iii. At minimum, have a re-credentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI). iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs. v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI.	▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness ▪ Criminal background checks ▪ Monitoring of continued licensure/and or certification ▪ Monitoring of sanctions

		vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must undergo state CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review. vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or re-credentialing. viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from las/regulation. ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof. x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract. xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute.	
CR10*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Utilization Management			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
UM1	4.2.4.F	**4.2.4.F** Drug Utilization Review (DUR) Program. In accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October 1, 2019, requiring the Contractor to implement provisions intended to monitor opioid and antipsychotic prescription utilization, the Contractor shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Contractor shall include review of Mental Health/Substance Use Disorder drugs, opioid and antipsychotic drugs in its DUR program. The State or its agent shall provide its expertise in developing review protocols and shall assist the Contractor in analyzing MH/SUD, opioid and antipsychotic drug utilization. Results of the review shall be provided to the State or its agent and, where applicable, to the Contractor's network providers. The State or its agent will take appropriate corrective action to report its actions and outcomes to the Contractor.	▪ Policies and Procedures addressing the following: ➢ Formulary Denials ➢ Prior Authorization Requests ➢ Type of Drug Denials ➢ Denial Criteria ➢ That scripts written by mental health/substance use disorder providers do not require prior authorization ➢ Pharmacy Prior Authorization ▪ Drug Utilization Review Program Description ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Various retrospective reports looking at the utilization of drugs in relationship to fraud and abuse (narcotics) over/under utilization of specific drugs, and mental health/substance use disorder drugs ▪ Various reports revealing clinical conflicts as related to drug interactions, drug-allergy conflicts, drug-disease conflicts, cumulative early refill, therapeutic duplication, drug exceeding maximum daily dosage, drug under minimum daily dosage, drug-age conflict, drug-gender conflict and duration of therapy ▪ Initiatives Developed to Address Deficiencies including Outcomes
UM2	4.6.1.C.3	**4.6.1.C.3** Enrollee Rights and Responsibilities. Shall include the right to the Medicaid Fair Hearing Process for Medicaid enrollees.	▪ Policy and Procedure addressing the following: ➢ Medicaid Fair Hearing Process ➢ Adverse Determinations ➢ Member Appeals ▪ Certificate of Coverage ▪ Cited page/s in the Provider Manual

			▪ MCO Website ▪ Notice of Action ▪ Member Handbook
Sub-heading	4.6.4 B.4.14.XIII Appendix	**4.6.4** **B.4.14.XIII** The Contractor shall develop a written Utilization Review Plan that includes all standards described in the NJ QAPI Standards.	
UM3	4.6.4.A B.4.14.XIII Appendix	**4.6.4.A** Utilization Review Plan. The Contractor shall develop a written Utilization Review Plan that includes all standards described in the New Jersey QAPI Standards (See Section B.4.14 of the Appendices) and the standards provided in Article 4.4 for MLTSS and DDD behavioral health utilization management. Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. **B.4.14.XIII** **A. written program description** - The organization has a written utilization management program description which includes at a minimum: • procedures to evaluate medical necessity and the criteria and tools used for MLTSS Members • procedures to evaluate functional care needs and authorize services to address those needs • information sources and the process used to review and approve the provision of services • the mechanism and metrics used to evaluate the utilization management program effectiveness **B. scope** - The program has mechanisms to detect underutilization as well as overutilization.	▪ Utilization Management Program Description ▪ QI Work Plan ▪ CAHPs reports ▪ Provider Surveys ▪ Documentation for Delegated Entities ➢ Policies and Procedures ➢ Workflows ➢ MCO's role in oversight of Delegated Entities
UM4		**In 2019, this element (UM4) was removed – Contract requirements will be addressed under UM3.**	
UM5	4.6.4.A.10	**4.6.4.A.10** **Prohibited Actions** Neither the Contractor's UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the Contractor's UM committee nor its	▪ Policies and Procedures addressing the following: ➢ Member and Provider Appeals ➢ Prior Authorizations ➢ Adverse Determinations ▪ Adverse Determination Letters ▪ Provider Manual ▪ Member Handbook

		utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.	
UM6	4.6.4.B	**4.6.4.B** **Prior Authorization** The Contractor shall have policies and procedures for prior-authorization and have in effect mechanisms to ensure consistent application of service criteria for authorization decisions.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ UM Program Description ➢ Clinical Criteria for UM decisions ➢ Inter-Rater Reliability Testing Policy and Procedure ▪ Inter-Rater Reliability Testing Results
UM7	4.6.4.B	**4.6.4.B** Prior authorization shall be conducted by a currently licensed, registered or certified health care professional, including a registered nurse or a physician who is appropriately trained in the principles, procedures and standards of utilization review.	**Assessment will also include a file review to verify compliance.** **Requires a State-approved policy and procedure.** ▪ QI Program Description ▪ UM Program Description ▪ Inter-rater Reliable Policy and Procedure ▪ UM Reviewer Job Description ▪ Physician-Reviewer Job Description ▪ Resumes/Bios ▪ Pharmacy personnel making authorizations for pharmaceuticals job description
Sub-heading	4.6.4.B	**4.6.4.B** The following timeframes and requirements shall apply to all **prior authorization** determinations:	
UM8	4.6.4.B.1	**4.6.4.B.1** **Routine determinations** Prior authorization determinations for non-urgent services shall be made and a notice of approved determination provided by telephone or in writing to the provider within fourteen (14) calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352, 42 CFR 438.404(c), NJAC §11:24, and the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq . The dental prior authorization shall be active for a minimum of six (6) months.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM9	4.6.4.B.2	**4.6.4.B.2** **Urgent determinations** Prior authorization determinations for **urgent services** shall be made within twenty-four (24) hours of receipt of the necessary information, but no later than	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations

		seventy-two (72) hours after receipt of the request for service. Written notification shall be provided in accordance with the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq.	➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM10	4.6.4.B.3	**4.6.4.B.3** **Determination for Services that have been delivered** (retrospective.) Determinations involving health care services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM11	4.6.4.B.4	**4.6.4.B.4** **Adverse Determinations** A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination in all adverse determinations. A NJ licensed orthodontist shall make the final determination in all adverse determinations for comprehensive orthodontic treatment service requests.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Consultant/Medical Peer Review Process ▪ UM Program Description
UM12	4.6.4.B.5	**4.6.4.B.5** **Continued/Extended Services** A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's health care provider, by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of an enrollee currently receiving inpatient hospital service or emergency room care, the Contractor shall make the determination involving continued or extended health care services within 24 hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. For services that require multiple visits, a series of tests, etc. to complete the service, the authorized time period shall be adequate to cover the	▪ Policies and Procedures addressing the following: ➢ Concurrent Review ➢ Authorization Timeframes ▪ Excel spreadsheet of concurrent review activity with request date, decision date, date of consultation with referring provider, date of enrollee and provider notification

		anticipated span of time that best fits the service needs and circumstances of each individual enrollee.	
UM13	4.6.4.B.6	**4.6.4.B.6** **Reconsiderations** The Contractor's policies and procedures for authorization shall include consulting with the requesting provider when appropriate. The Contractor shall have policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring provider. Determinations in such cases shall be made within the timeframes established for initial considerations.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ UM Program Description
UM14	4.6.4.B.7	**4.6.4.B.7** The Contractor shall provide written notification to enrollees and/or, where applicable, an authorized person at the time of denial, deferral or modification of a request for prior approval to provide a medical/dental/behavioral health/MLTSS service(s) when the following conditions exist: a. The request is made by a medical/dental or other health care provider who has a formal arrangement with the Contractor to provide services to the enrollee. b. The request is made by the provider through the formal prior authorization procedures operated by the Contractor. c. The service for which prior authorization is requested is a Medicaid covered service for which the Contractor has established a prior authorization requirement. d. The prior authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring or modifying the service requested but prior to the point at which the enrollee must initiate the Contractor's appeal process.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ Notice of Action ▪ Tracking System
UM15	4.6.4.B.8	**4.6.4.B.8** **Notice of Action** shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. The member, member's authorized representative, and provider acting on behalf of a member with the member's written consent (if the latter is applicable) shall receive written notice of any adverse determination within two business days of said determination. The written notice shall be generated on the date of the determination. In the case of expedited appeal process, the Contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, and the enrollee (or their authorized representative) of the following: a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other coverage determination;	▪ Policies and Procedures addressing the following: ➢ Adverse Determinations ▪ Notice of Action Letter templates – Enrollee and Provider ▪ Examples of Notice of Action Letters – Enrollee and Provider

		b. The enrollee's rights to, and method for obtaining, an external (IURO) appeal and/or Fair Hearing to contest the denial, deferral or modification action; c. The enrollee's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, or a friend or other spokesperson designated in writing as an authorized representative; d. The action taken or intended to be taken by the Contractor on the request for prior authorization and the reason for such action including clinical or other rationale and the underlying contractual basis or Medicaid authority; e. The name and address of the Contractor; f. Notice of internal (Contractor) appeal rights and instructions on how to initiate such appeal; g. Notice of the availability,of the clinical or other review criteria relied upon to make the determination; h. The notice to the enrollee shall inform the enrollee that he or she may file an appeal concerning the Contractor's action using the Contractor's appeal procedure prior to or concurrent with the initiation of the State hearing process; i. The Contractor shall notify enrollees, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352 42 CFR 438.404(c), and in NJAC §11:24-8.3; j. The enrollee's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal.	
UM16*/**	5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.4 4.6.4.B.5 4.6.4.B.7 4.6.4.B.8	**5.8.2.F** **Grievances and Appeals** 1. Procedures for resolving grievances, as approved by the DMAHS. 2. A description of the grievance/appeal procedures to be used to resolve an adverse benefit determination, including: the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in adverse benefit determination appeals; the time frames and circumstances for expedited and standard appeals; the right to appeal an adverse benefit determination; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 3. The Contractor shall notify all enrollees in their primary language of their rights to file grievances and appeals by the Contractor. 4. An explanation that, in addition to the MCO Appeal process, Medicaid/NJ FamilyCare A enrollees, and NJ FamilyCare ABP enrollees have the right to a Fair Hearing (which must be requested within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal with DMAHS and the appeal process through the New Jersey Department of Banking and Insurance (DOBI), including instructions on the procedures involved in making such a request.	**Requires a State-approved policy and procedure addressing the grievances and appeals.** ▪ Policies and Procedures addressing the following: ➢ Prior Authorization processes ➢ Enrollee, appeals, and grievances ➢ Provider, appeals, and grievances ▪ Tracking logs ▪ Letters templates ▪ Examples of Provider/Enrollee letters ▪ Member Handbook ▪ Provider Manual

		5. Notification that benefits that the Contractor seeks to reduce, suspend, or terminate will continue while an appeal is pending if the enrollee files an appeal or a request for Fair Hearing (and requests that benefits continue during the Fair Hearing) within the timeframes specified at 4.6.4.C, and that the enrollee may be required to pay the cost of services furnished while the Fair Hearing is pending if the final decision is adverse to the enrollee. **5.15.1.A** DMAHS Approval. The Contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of grievances and appeals by enrollees. The grievance and appeal policies and procedures shall be in accordance with. 42 C.F.R. 438, with the modifications that are incorporated in the contract. The Contractor shall not modify the grievance/appeal procedure without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The Contractor's grievance/appeal procedures shall provide for expeditious resolution of grievances/appeals by Contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management grievances/appeals. (For the utilization management appeal process, see Article 4.6.4C.) The Contractor shall review the grievance/appeal procedure at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure. The Contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All enrollees have available the grievance and appeal processes under the Contractor's plan, the Department of Banking and Insurance and, for certain NJ FamilyCare beneficiaries (i.e., Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees), the Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, do not have the right to a Fair Hearing. **6.5.B** Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting.	

		4.6.4.B.1, 2, 3, 4, 5, 7, 8: See above elements for contract language relating to UM files and appeals.	
UM16a* Member Grievances – Core Medicaid			▪ File Review
UM16b* Provider Grievance – Core Medicaid			▪ File Review
UM16c* Member Appeals – Core Medicaid			▪ File Review
UM16d* Provider Appeals – Core Medicaid			▪ File Review
UM16e* UM – Core Medicaid			▪ File Review
UM16f** Member Grievance – MLTSS			▪ File Review
UM16g** Provider Grievance – MLTSS			▪ File Review
UM16h** Member Appeals – MLTSS			▪ File Review
UM16i** Provider Appeals – MLTSS			▪ File Review

UM16j** UM - MLTSS			▪ File Review
UM17	4.6.4.C	**4.6.4.C** **Appeal Process for UM Determinations** The Contractor shall have policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.	▪ Policies and Procedures Addressing the following: ➢ Prior Authorizations ➢ Addressing Timeliness of Decisions ➢ Adverse Determinations ➢ Enrollee and Provider Appeals ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Notice of Action ▪ Member Handbook ▪ Provider Manual
UM18	B.4.14.XIII.C Appendix	**B.4.14.XIII.C** **Pre-authorization and concurrent review requirements** For organizations with preauthorization or concurrent review programs: 1. The organization implements written policies and procedures, reflecting current standards of medical practice and standards of functionality for long term services and supports, for processing requests for initial authorization of services or requests for continuation of services. a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services. b) Criteria for decisions on coverage, medical and /or functional necessity and service authorization are clearly documented, are based on reasonable medical evidence, or a consensus of relevant health care professionals, or policy guidance by DMAHS and are regularly updated. c) Mechanisms are in place to ensure consistent application of review criteria and comparable decisions on service authorizations are made across reviewers, including Medical Directors.	▪ Policies and Procedures addressing the following: ➢ Monitoring the effects of UM program using enrollee and provider satisfaction data ➢ UM program analysis using enrollee and provider satisfaction data ▪ Improvement Plans ▪ Outcome Data

		d) A clinical peer, in a same or similar specialty, reviews all decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and /or functional appropriateness. The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services, including MLTSS. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing. e) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. f) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process. g) Mechanisms are in effect to detect both underutilization and overutilization of services. 2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals with appropriate subject matter expertise in the populations and services being authorized. 3. Efforts are made to obtain all necessary information, including pertinent clinical and/or functional information, and consult with the treating provider as appropriate. 4. The reasons for decisions are clearly documented and available to the Member. 5. There are well-publicized and readily available appeals mechanisms for both providers and Members. Notification of a denial includes a description of how to file an appeal. 6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation. 7. There are mechanisms to evaluate the effects of the program using data on Member satisfaction, provider satisfaction or other appropriate measures. 8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.	

UM19*/**	B.9.0 MLTSS Service Dictionary for PDN services. 4.5.3.H N.J.A.C. §10:60-5.4(b)	**B.9.0 MLTSS Service Dictionary** Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care. The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services. MLTSS Private Duty Nursing Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program. Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care **4.5.3.H** Individuals who are 20 years and older with an intellectual/developmental disability who are identified as receiving Private Duty Nursing shall be referred to the Division of Developmental Disabilities for consideration of the DDD Supports Plus Private Duty Nursing (SPPDN) program. If SPPDN is indicated the MCO shall complete a NJ Chose Assessment when the member is 20.5 years or older and submit the OCCO as assessment type “4” Supports along with the DDD determination. If the member meets Nursing Faculty Level of Care and DDD program requirements the member will be enrolled into the program. A NJ Choice assessment is required annually for all members enrolled in SPPDN program.	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Prior Authorization ▪ Case Examples ▪ Tracking Mechanisms ▪ Member Handbook ▪ Oversight Documentation ▪ Denial Letters ▪ New Jersey Choice Assessment Narrative ▪ Special Care Nursing Facility Level of Care Approval Request

		N.J.A.C. §10:60-5.4(b) (b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below: 1. A requirement for all of the following medical interventions: i. dependence on mechanical ventilation; ii. the presence of an active tracheotomy; and iii. the need for deep suctioning; or 2. A requirement for any of the following medical interventions: i. the need for around-the-clock nebulizer treatments, with chest physiotherapy; ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or iii. a seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anti-convulsants.	
UM20*/**	9.6.5.E 9.6.5.I N.J.A.C. §10:60-5.5(f)3	**Private Duty Nursing Services** **9.6.5.E MLTSS** The Care Manager shall continuously assess/identify a problem or situation and take appropriate action. The Care Manager shall provide more frequent case monitoring when the Care Manager is notified of an urgent/emergent need or change of condition that may require revisions to the existing plan of care. The Care Manager shall conduct a face-to-face visit within twenty-four(24) hours when the situation resulting from the need or change of condition cannot be handled over the telephone or when the Care Manager has reason to believe the Member's well-being is at risk. **9.6.5.I** The Care Manager shall update the written plan of care, in accordance with the Member's assessed needs and goals, at each visit. The Member must indicate his/her agreement with the plan of care each time there is an increase or reduction in services. The Care Manager shall provide the Member a copy of the revised and signed plan of care. **N.J.A.C. §10:60-5.5(f) EPSDT** A nursing reassessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following: 1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services. 2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s).	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Tracking Mechanisms ▪ Documentation Standards ▪ Care Plans ▪ Oversight Documentation ▪ MLTSS Plan of Care or Service Plans

		3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.	
UM21		**In 2019, this element (UM21) was removed and will no longer be reviewed.**	
UM22*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Administration and Operations			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
AO1	4.9.3.A 4.9.3.B	**4.9.3.A** The Contractor shall comply with all the provisions of the New Jersey MCO regulations at N.J.A.C. 11.24 et seq. regarding Provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the Members receiving a course of treatment; continuity of care; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and Members who reside in the county in which the hospital is located or in an adjacent county within the Contractor's service area. **4.9.3.B** The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, at least 45 days prior to the effective date of suspension, termination, non-renewal of contract, or voluntary withdrawal, or any other form of non-participation of a provider or subcontractor from participation in this program. The Contractor's notice to DMAHS and the MFD shall include the reason for the provider's non-participation in the plan. Failure to report the information required by this section and or failure to report the information in the time period specified will subject the contractor to the provisions of Section 7.36.6 of the Contract. If	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Member letter of specialist termination in English and Spanish ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination ▪ Notification to providers and enrollees of hospital termination/non-renewal with associated hospital termination/non-renewal date ▪ Notification to DMAHS of terminations ▪ Evidence of notification within 45 days

		the termination was "for cause", the Contractor's notice to DMAHS shall include the reasons for the termination. 1. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers. 2. The Contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date. 3. The Contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.	
AO2	4.9.3.C	**4.9.3.C** If a primary care provider ceases participation in the Contractor's organization, the Contractor shall provide written notice at least thirty (30) days from the date that the Contractor becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice within fifteen days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination
AO3*	5.7.A	**5.7.A** The Contractor shall have in place a Member Services Unit to coordinate and provide services to Medicaid/NJ FamilyCare managed care enrollees. The services include, but are not limited to, enrollee selection, changes, assignment, and/or reassignment of a PCP, explanation of benefits, assistance with filing and resolving inquiries, billing problems, grievances and appeals, referrals, appointment scheduling and cultural and/or linguistic needs. This unit shall also provide orientation to Contractor operations and assistance in accessing care.	▪ Customer Service Departmental Organizational Chart ▪ Customer Service Staff Job Descriptions ▪ Customer Service Department Training Manual ▪ Ongoing Training Materials ▪ Customer Service Desk-Top Procedures ▪ Customer Service Department Orientation schedules ▪ Service Standards ▪ Monitoring reports and documentation showing efforts to address identified deficiencies ▪ Review of Call Center systems
AO4	5.8.5.A 7.24.M	**5.8.5.A** Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days	▪ Policies and Procedures addressing the following: ➢ Customer Service Department

		after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information: 1. Name of enrollee 2. Issue date for use in automated care replacement process 3. PCP name "or your Medicare PCP" (may be affixed by sticker) 4. PCP phone number (may be affixed by sticker) 5. What to do in case of emergency and that no prior authorization is required 6. Relevant co-payments/personal contributions to care 7. Contractor 800 number – emergency message 8. Dental Benefit information. The contractor will provide information on the contractor ID card to assist members with obtaining information for the NJFC dental benefit. If dental services are provided through a subcontractor, both the name of the Contractor and the subcontractor must appear on the card. a. The contractor ID card includes Dental Services as a benefit on the card and a toll free contact number (may be affixed by sticker for existing members) b. For those enrollees that are assigned and change PCD and for new enrollees that are assigned a PCD, a separate ID card from the contractor shall be included in the letter that provides information for the selected or assigned PCD (dentists/dental group). It will include: 1. Name of enrollee 2. Issue Date for use in automated card replacement process 3. Primary Care dentist/office Phone Number 4. Relevant copayments/Personal Contributions to Care 5. Contractor 800 number – indicate types of assistance such as dental benefit questions/assistance 6. Subcontractor 800 number – indicate types of assistance such as assistance in locating a dentist Any additional information shall be approved by DMAHS prior to use on the ID card. **7.24.M** M. The Contractor shall, on a monthly basis, submit a report indicating all undeliverable member identification cards in the format prescribed by DMAHS. The Undeliverable ID Card Report shall be submitted to the State's Health Benefits Coordinator.	➢ New Member Process ➢ Post Enrollment ID Card Production ▪ Customer Service Departmental ID Card Production Reports ▪ Monitoring Reports ▪ Example of current ID Card ▪ Example of Dental ID Card for members with PCD
Sub-heading	4.9.6	**4.9.6** **Subcontracts:** In carrying out the terms of the contract, the Contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or	

		administrative services as defined in Article 1. In doing so, the Contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.	
AO5	4.9.6.A - I	**4.9.6.A-I** A. All subcontracts shall be in writing and shall be submitted to DMAHS for prior approval at least 90 days prior to the anticipated implementation date. DMAHS approval shall also be contingent on regulatory agency review and approval. B. The Department shall prior approve all provider contracts and all subcontracts. C. All provider contracts and all subcontracts shall include the terms in Section B.7.2 of the Appendices, Provider/Subcontractor Contract Provisions. D. The Contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the Contractor and the Department. E. Unless otherwise provided by law, Contractor shall not cede or otherwise transfer some or all financial risk of the Contractor to a subcontractor. F. Every third party administrator engaged by the Contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267 G. All Contractors entering into subcontracts with other entities for the provision of health care services should also comply with requirements under 42 CFR 438.6(l), 42 CFR 438.230(a),42 CFR 438.230(b)(1), (2), (3). H. All subcontractors are to comply with requirements in terms of this contract listed in 5.8.2 Enrollee Notification and Handbooks and 6.2 Provider Publications. These documents are to be subject to DMAHS review and approval following the same timelines and requirements as comparable documents produced by contractors. I. Any subcontract where the subcontractor (vendor) provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.	▪ Provider Participation Agreement Template Letter ▪ Administrative Services Agreement between MCO and Service Provider ▪ Copies of agreements or subcontracts with other entities contracted to provide services to MCO enrollee ▪ Contracts between the MCO and subcontractor ▪ QI Program Description ▪ Annual QI Program Evaluation

AO6	7.3.A	**7.3.A** **Staffing**: The Contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The Contractor shall demonstrate to DMAHS' satisfaction that it has the necessary dedicated, non-delegable New Jersey staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum: 1. A designated administrative liaison for the Medicaid/NJ FamilyCare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative") 2. A full-time Medical Director(s) who shall be licensed as an M.D. or D.O. in New Jersey and meets the experience requirements pursuant to Article 4.6.1(C)(2). 3. A full-time senior executive dedicated to MLTSS who has at least five (5) years of experience administering managed long term care programs. Equivalent experience administering long term care programs and services, including HCBS, or in managed care may be substituted, subject to DMAHS approval. 4. A Dental Director - who shall be licensed as a DDS or DMD in New Jersey 5. A behavioral health administrator who is a New Jersey licensed social worker (LSW), licensed registered nurse (RN), clinical nurse specialist (CNS), licensed advanced practice nurse (APN), physician or psychologist with experience serving chronically ill populations with mental health and Substance Use Disorders, a minimum of three (3) years of experience serving in a managerial/leadership role and knowledge of managed care. 6. Financial officer(s) or accounting and budgeting officer 7. QM/UR coordinator who is a New Jersey-licensed registered nurse or physician 8. Prior authorization staff sufficient to authorize medical, behavioral, dental and MLTSS services twenty-four (24) hours per day/seven (7) days per week 9. A full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff. 10. A designated Care Manager or supervisor to act as administrative liaison between the Contractor and the various State entities for the MLTSS Care Management requirements set forth in this contract. At a minimum, this individual shall meet the Care Manager requirements pursuant to Article 9.5.2 and have a minimum of four (4) years experience serving enrollees receiving long term services and supports. 11. Designated Medicaid Care Manager(s) who shall be available to DMAHS medical staff to respond to medical, behavioral or MLTSS related problems, grievances, and emergent or urgent situations 12. Member services unit head	▪ Organizational Chart ▪ Individual Departmental Organizational Charts ▪ Key staff job descriptions listing essential duties and responsibilities, education, experience, required qualifications, licensure and/or certification for the position

		13. Provider services unit head as well as a provider services liaison dedicated to MLTSS. The Contractor shall identify one or more MLTSS provider representatives for MLTSS providers. MLTSS provider representative(s) shall be responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing and other MLTSS provider needs. The MLTSS provider representatives shall conduct ongoing communications with MLTSS providers through provider forums, webinars, dedicated toll-free MLTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes 14. Encounter reporting staff/claims processors supervisors 15. Grievance coordinator 16. A full-time designated MLTSS Member Representative responsible for internal representation of the interests of MLTSS Members including but not limited to input into planning and delivery of long term services and supports, participation in QM/QI activities, assistance with program monitoring and evaluation, and provision of education to enrollees, families, and providers on issues related to the MLTSS program. The MLTSS Member Representative shall assist MLTSS Members in navigating the Contractor's system. This shall include, but not be limited to, helping MLTSS Members understand and use the Contractor's system, being a resource for MLTSS Members, providing information, making referrals to appropriate Contractor staff Members, and facilitating resolution of any issues. The MLTSS Member Representative shall make recommendations to the Contractor on any changes needed to improve the Contractor's system for MLTSS Members, and participate as an ex officio Member of the Contractor's Consumer Advisory Committee. 17. A Nursing Facility Transition/Money Follows the Person program staff person possessing the skill and knowledge to assist in coordinating and facilitating Member transition from nursing facilities to the community. 18. A Participant Direction liaison who is knowledgeable in the process of service delivery through participant direction. This person will serve as the liaison between the MCO, the Member and the state to facilitate communication and ensure appropriate coordination of services. 19. Adequate administrative and support staff 20. Compliance Officer 21. A dedicated Housing Specialist(s) who shall be responsible for helping to identify, secure, and maintain community-based housing for MLTSS Members and for developing, articulating, and implementing a broader housing strategy within the Contractor to expand housing availability/options. The Housing Specialist(s) shall act as the Contractor's central housing expert(s)/resource(s), providing education and assistance to all Contractor's relevant staff (care managers and others) regarding supportive housing services and related issues for MLTSS	

		Members. The Housing Specialist(s) shall be a dedicated staff person whose primary responsibility is housing-related work. The Housing Specialist shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO. The Housing Specialist shall act as a liaison with DMAHS staff, or its designee, to receive training and capacity building assistance. The Housing Specialist(s) shall provide quarterly reports to DMAHS regarding the Contractor's progress towards identified housing goals/strategies and its quality monitoring activities. a. The Housing Specialist(s) shall have at least three (3) years' full-time experience in assisting vulnerable populations (e.g. homeless, elderly, people with disabilities, etc.) to secure accessible, affordable housing. The Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources. b. The Contractor shall provide evidence of the aforementioned qualifications for those individuals or entities hired/designated as Housing Specialist(s) if requested by DMAHS. 22. A New Jersey dedicated Pharmacy Director	
AO7	7.3.C	**7.3.C** **Training** The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. The Contractor shall ensure compliance with all mandated training programs as required by DMAHS. The Contractor shall comply with Article 9.5.3 and 9.5.4 regarding MLTSS staff training.	▪ Policies and Procedures addressing the following: ➢ Staff Selection and Placement, Retention, and Background Checks ➢ Examples of Website Training Programs Screen Print ➢ General Orientation Materials ➢ Departmental Orientation Documents ➢ Ongoing Training Documents ➢ Resumes/Bios ➢ Job Descriptions
Sub-heading	B.4.14.VIII Appendix	**B.4.14.VIII** **Delegation of QAPI Activities** The MCO remains accountable for health services management and all QAPI functions, including those pertaining to MLTSS even if certain functions are delegated to other entities.	
AO8	B.4.14.VIII.B Appendix	**B.4.14.VIII.B**	▪ Policies and Procedures addressing the following:

		The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care provided.	➢ Monitoring and Evaluating Delegated Activities ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Evidence of monitoring activities
AO9	B.4.14.VIII.C Appendix	**B.4.14.VIII.C** The MCO has evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.	▪ Delegation Oversight Audits and findings including any corrective action ▪ Entire Year of the most recent committee oversight meeting minutes such as Credentialing Committee and Medical Management
AO10	B.4.14.VIII.D Appendix	**B.4.14.VIII.D** The MCO evaluates the entity's ability to perform the delegated activities prior to delegation.	▪ Policies and Procedures addressing the following: ➢ Evaluation Prior to Delegation ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Pre-Delegation Evaluation Audit findings
AO11	B.4.14.VIII.E Appendix	**B.4.14.VIII.E** If the MCO delegates selection of providers to another entity, the Contractor shall have retained the right to approve, suspend, or terminate any provider selected by that entity.	▪ Quality Improvement Program Description ▪ Credentialing Program ▪ Policies and Procedures addressing the following: ▪ Delegation Agreement Process and Structure ▪ Credentialing Delegation – Scope of Work and Performance Standards ▪ Credentialing Committee Charter ▪ Delegation Agreements ▪ Entire Year of the most recent Credentialing Committee Meeting Minutes
AO12**	4.8.1.M 4.9.2.E	**4.8.1.M** **MLTSS Any Willing Provider and Any Willing Plan** 1. MLTSS Any Willing Providers are any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury. The definition also applies to long term care pharmacies that apply to become network providers. These Medicaid Providers must comply with the Contractor's provider network participation requirements and are included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form which is known as	▪ Evidence of compliance with AWP requirements – procedures relating to contracting for NFs, SCNFs, ALs and CRSs; ▪ Contracts executed to serve MLTSS population ▪ Correspondence with providers requesting participation

		Any Willing Plan. The Contractor must accept all NFs, SCNFs, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard. 1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2021, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2022. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. 2. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, performance on specified quality metrics , or other factors dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers. 3. The Any Willing Plan status also expires June 30, 2022. **4.9.2.E** **Contract Submission**: MLTSS provider contracts and subcontracts – The Contractor shall include the MLTSS Any Willing Provider (AWP) and contract term period provisions as necessary and as detailed at 4.8.1M. The Contractor shall contract with all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0) and include all required provider specification requirements. These include, but are not necessarily limited to: 1. Nursing Facility - The Contractor shall include in Custodial and Rehabilitation facility contracts, a notice requirement for the facility/provider to contact the Contractor prior to or within 24 hours of admission for authorization of care. 2. Adult Family Care a. Licensed Adult Family Care Sponsored Agency (AFC) – licensed by HFEL (Health Facilities Evaluation and Licensing) 3. Assisted Living Services (ALR, CPCH) – Assisted Living Facility a. Assisted Living Residences (ALR) b. Comprehensive Personal Care Home (CPCH) 4. Assisted Living Program (ALP) 5. TBI Behavioral Management (Group and Individual) 6. Caregiver/Participant Training 7. Cognitive Therapy (Group and Individual) 8. Community Residential Services (CRS)	

		9. Medical Day Services 10. MLTSS PCA a. The Contractor shall, in any Provider contract for personal care services, require that the increase in hourly rate above the hourly rate paid in state fiscal year 2018 be used solely to increase payments to workers who directly provide personal care services consistent with P.L. 2017, c. 239 1. b. The Contractor shall, in any Provider contract for personal care services, inform the Provider that it will be required to report to DMAHS showing compliance with the requirement to increase payments to direct care workers consistent with P.L. 2017, c. 239 2. 11. Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy (Group and Individual) 12. Private Duty Nursing (Adult) 13. Specialized Medical Equipment and Supplies and Evaluation 14. Supported Day Services 15. Non-Traditional Provider Contracts –All model contract forms with Non-Traditional providers shall be submitted on a file and use basis thirty (30) days prior to the effective date, and shall comply with all applicable State and federal laws. Services may include: Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, Medication Dispensing Devices and Monthly Monitoring, Non-Medical Transportation; Personal Emergency Response System (PERS) Device, Set Up, and Monitoring, Residential and Vehicle Modifications, Respite, Social Adult Day Care, Structured Day Program.	
AO13*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

AO14*	4.7.2.A.9	**4.7.2.A.9** **Report of Accreditation Status** a. Contractor is required to inform the State, at least annually and upon any change of accreditation, whether it has been accredited by a private independent accrediting entity. b. Contractors that have received accreditation by any private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including: i. Accreditation entity name ii. Accreditation status, survey type, and level (as applicable) iii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings, and iv. Expiration date of the accreditation. c. Contractors must make the accreditation status available on their Web sites to include: I. Whether the Contractor has been accredited by a private independent accrediting entity II. the name of the accrediting entity, accreditation program, and accreditation level (as applicable) III. Update this information annually or more frequently if that are any changes in accreditation.	▪ Evidence of annual notification to DMAHS of accreditation status, or more frequently if there are any changes in accreditation.
Management Information Systems			
2022 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	3.1.2.A	**3.1.2.A** **Timely Processing** The Contractor shall provide for timely updates and edits for all transactions on a schedule that allows the Contractor to meet the State's performance requirements. At a minimum, this shall include the following:	
IS1	3.1.2.A.1	**3.1.2.A.1** Enrollee and provider file updates to be daily;	▪ Sample Reports ▪ Daily Updated Enrollee Files Report ▪ Policies and Procedures addressing the following: ➢ Frequency of Enrollee and Provider File Updates
IS2	3.1.2.A.2	**3.1.2.A.2** Reference file updates to be at least weekly or as needed;	▪ Sample Reports

			▪ Policies and Procedures addressing the following: ➢ Frequency of Reference File Updates
IS3	3.1.2.A.3	**3.1.2.A.3** Prior authorizations and referral updates to be daily;	▪ Sample Pre-Service Request Turn-around Time Reports ▪ Sample Pre-Service Request Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Prior Authorization and Referral Updates
IS4	3.1.2.A.4	**3.1.2.A.4** Claims and encounters to be processed (entered and edited) daily;	▪ Paid, Incurred, and Pended Claims Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Claims and Encounters Processing
IS5	3.1.2.A.5	**3.1.2.A.5** Claim payments to be at a minimum biweekly except as necessary to meet the requirements in Article 7.16.5	▪ Example of Provider Remittance Inventory with receipt date ▪ Policies and Procedures addressing the following: ➢ Claims Processing
IS6	3.1.2.A.6	**3.1.2.A.6** Capitation payments to be monthly	▪ Policies and Procedures addressing the following: ➢ Capitation Payment Processing ➢ Check Register Lists
IS7	3.1.3.A	**3.1.3.A** **Regular Reporting** The Contractor's system shall provide sufficient reports to meet the requirements of this contract as well as to support the efficient and effective operation of its business functions. The required reports, including time frames and format requirements, are in Section A of the Appendices.	▪ Master Report Schedule ▪ Compliance Tracking Documents
IS8	3.1.3.B	**3.1.3.B** **Ad Hoc Reporting** The Contractor shall have the capability to support ad hoc reporting requests, at no additional cost, in addition to those listed in this contract, both from its own organization and from the State in a reasonable time frame. The time frame for submission of the report will be determined by DMAHS with input from the Contractor based on the nature of the report. DMAHS shall at its option request six (6) to eight (8) reports per year, hardcopy or electronic reports and/or file extracts. This does not preclude or prevent DMAHS from requiring, or the Contractor from	▪ Information System (IS) Data Reporting Request Form ▪ Sample of Ad Hoc Reports ▪ IS Vendor Request Form ▪ Provider Data Reporting Request Form

		providing, additional reports, at no additional cost, that are required by State or federal governmental entities or any court of competent jurisdiction.	
IS9	3.7.1.A 3.7.1.A.3	**3.7.1.A** The system shall provide data to assist in the definition and establishment of Contractor performance measurement standards, norms and service criteria. **3.7.1.A.3** It should maintain data for medical, behavioral, dental and MLTSS assessments and evaluations.	▪ Sample Performance Reports ▪ HEDIS® Reports ▪ MLTSS assessment and evaluation reports
IS10	3.7.1.A.7	**3.7.1.A.7** Reports should facilitate at a minimum monthly tracking and trending of enrollee care issues to monitor and assess Contractor and provider performance and services provided to enrollees.	▪ Policies and Procedures addressing the following: ➢ Tracking and Trending ➢ Monthly Tracking Reports such as: ➢ Quality of Care/Service ➢ Grievances ➢ Utilization of Services ➢ Access and Availability
IS11	3.8	**3.8** The MCMIS shall have a comprehensive reporting capability to support the reporting requirements of this contract and the management needs for all of the Contractor operations.	▪ Grievance Reports ▪ Pended Claims Reports ▪ Quality Reports ▪ Sample of canned reports such as: ▪ Member grievance report ▪ Monthly dashboard reports ▪ Monthly pended claims report
IS12	3.8.1.D	**3.8.1.D** The Contractor shall acquire the capability to receive and transmit data in a secure manner electronically to and from the State's data centers, which are operated by OIT. The standard data transfer software that OIT utilizes for electronic data exchange is Connect: Direct. Both mainframe and PC versions are available. A dedicated line is preferred, but at a minimum connectivity software can be used for the connection.	▪ Flowchart of Network Process ▪ Data Transfer Procedure ▪ A Screen Print of Logins ▪ Confirmation correspondence from DMAHS showing receipt of electronically submitted data
IS13	3.1.2.F	**3.1.2.F** If the Contractor uses different systems or engages in a delegated or sub-contracting arrangement for physical health, behavioral health and/or long-term services and supports, these systems shall be interoperable with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.	▪ Flowchart showing integration of data from delegated entities ▪ Demonstration of plan access to delegated services
IS14***	3.1.2.G	**3.1.2.G**	▪ Demonstration of document management for MLTSS

		The Contractor shall ensure that images of documents used by Members and providers to support Care Management processes are indexed and maintain logical relationships to certain key data such as Member identification and provider identification number.	▪ Review of MLTSS CM system
IS15**	3.1.2.I	**3.1.2.I** The Contractor's system shall be able to electronically track, store and share real-time the end- to-end data necessary to complete MLTSS Care Management processes for enrollees receiving long term services and supports including but not limited to, systems alerts for changes related to identification of potential members and the referral date of MLTSS clinical eligibility evaluation, MLTSS status, financial data, clinical eligibility status, NJ Choice assessment system assessment data, and plan of care data. See Article 9.2 for additional detail on the Member's electronic Care Management record.	▪ System documentation regarding tracking of alerts ▪ Integration of new enrollees in MLTSS system ▪ Reporting of potential MLTSS members ▪ Review of MLTSS system onsite
IS16	3.1.2.J	**3.1.2.J** The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level. If the Contractor's integrated systems include other lines of business, e.g. Medicare or commercial insurance, or Fully Integrated Dual Eligible (FIDE) SNP) or business in other states, those systems must have the capability to segregate the information by product line to allow for direct viewing of all Medicaid/NJ FamilyCare information by the State and/or its vendors.	▪ Documentation relating to capability of separating NJ specific LOBs ▪ Demonstration of electronic access to NJ CM, UM, Claims, Grievances for NJ DMAHS staff and their representatives ▪ Security documents/policies related to access to NJ LOB data
IS17**	3.1.2.K	**3.1.2.K** The Contractor's system shall include a means for the MLTSS Care Manager to ensure that home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary. This shall include either notification from providers or Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.	▪ Reports of services rendered to MLTSS members ▪ Flowchart on MLTSS reporting ▪ Demonstration of real time access to service data
IS18*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Appendix G2

2022 Core Medicaid Care Management Document Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** The Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**.

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7*	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool.	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	Reports showing outreach to Enrollees identified for CNA and completion results
CM8*	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCO must develop policies and procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement ➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18b	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18c	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details.	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19*	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports ▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6.5. I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5. L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change. **4.6.5.L** Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities ➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

New Jersey Annual Assessment of MCO Operations

Appendix G3
MLTSS HCBS CM
2022 MLTSS CM Audit Submission Guide

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.6 4.1.1.F.1 9.3.3 9.3.3.A 9.3.3.B 9.3.3.C 9.3.3.D 9.3.3.E 9.3.3.F 9.6.6.E 4.1.1.E 9.6.6.F	4.6.5.D.6 If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty-five (45) calendar days of the Member's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3 The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: 9.3.3.A Have a mechanism for allowing a Member to request and be granted a change of provider.	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.3.3.B Notify providers of their role in providing continuity of care for their members in transition. 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services. 9.3.3.D Work with the provider that is no longer willing or able to provide services to a Member to cooperate with the Member's Care Manager to facilitate a seamless transition to another provider and continue to provide services to the Member until the Member has been transitioned to the other provider. 9.3.3.E Have a mechanism for information exchange between providers in accordance with termination timeframes outlined in section 4.9.3; and 9.3.3.F Have a mechanism for ensuring confidentiality as specified in Article 7.38. 9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Members the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. Newly enrolled members who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1. B MLTSS Care Management Standards General Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-effective manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM28	9.5.1. D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long-term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health, and long-term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1. J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers, and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers, and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2. B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or	▪ Care Management job descriptions used in recruitment ▪ Organization Chart with CM names ▪ CM resumes

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members. 2. Caseload management and casework practices. 3. Human services principles for determining eligibility for benefits and services. 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A MLTSS Training The Contractor shall develop initial and ongoing training and education programs for all staff Members working with the MLTSS population on topics pertinent to interacting with and coordinating services for individuals receiving MLTSS benefits to ensure compliance with contract requirements. 9.5.4.A A. The Contractor shall develop standards for Care Management Training which includes the following components: 1. Training curriculum including goals of training, competency standards, and frequency of retraining 2. Quality Assurance program to identify inter/intra-rater reliability and core standards 3. Continue Quality Assurance standards to ensure standards are being met	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Remediation training plan for employees who do not meet the standards 9.5.4.B Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request.	
CM34	9.5.5. J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2. A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4. A	4.7.4. A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and, in the time, frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element

Care Management and Continuity of Care			
2021 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			and explanation should be given related to compliance.
CM38	9.4.1.A.4 9.5.1. E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy