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

FIDE SNP and MLTSS

External Quality Review

Annual Technical Report

Review Period: January 1, 2022–December 31, 2022

(2022–2023 Review Cycle)

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I. Executive Summary

Purpose of Report

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

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

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

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

Five FIDE SNPs, namely Aetna Assure Premier Plus (AAPP), Amerivantage Dual Coordination (AvDC), Horizon NJ TotalCare (HNJTC), UnitedHealthcare Dual Complete ONE (UHCDCO), and WellCare Dual Liberty (WCDL) participated in the FIDE SNP Program in 2022. The total FIDE SNP enrollment in AAPP, AvDC, HNJTC, UHCDCO and WCDL as of 12/31/2022 was 78,818 which is an increase from 65,617 FIDE SNP members from 12/31/2021.

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the three mandatory and two optional EQR activities that were conducted. External quality review (EQR) activities conducted during January 2022–December 2022 included annual assessment of MCO operations, Performance Measure (PM) validation, validation of Performance Improvement projects (PIPs), DMAHS encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey.

It should be noted that validation of network adequacy and assistance with the quality rating of MCOs was to be conducted at the states' discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. Validation of Network Adequacy and assistance with Quality Rating System was not conducted by IPRO during this review period. The updated protocols stated that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR Section § 438.358 Activities related to external quality review* (b)(1), these activities are:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Optional Protocol 5:* Validation of Encounter Data –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality of Care Surveys –** In 2021, one Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H Survey for NJ FIDE SNP enrollees was conducted to assess consumers' experiences with their health plan. The NJ FIDE SNP adult survey project consisted of 58 core questions and 11 supplemental questions.

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

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

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

High-Level Program Findings and Recommendations

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

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

Strengths and Opportunities for Improvement Related to Quality, Timeliness and Access

The EQR activities conducted in 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 ATR includes IPRO's evaluation of the April 2022 and August 2022 PIP report submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. It was determined that New Jersey FIDE SNP MCOs could submit their Chronic Condition Improvement Projects (CCIPs), approved by CMS, to meet the mandatory Performance Improvement Projects requirement. All MCOs were required to provide data at the New Jersey specific FIDE SNP level for these projects. IPRO deemed CMS acceptance of these projects for compliance with Performance Improvement Project validation. In addition to the CCIP projects submitted by the FIDE SNP MCOs, PIPs related to Access and Availability of Primary Care Services were also submitted and validated. Since Aetna Assure Premier Plus (AAPP) joined the New Jersey FIDE SNP network on January 1, 2021, the MCO was subject to submit PIPs for validation in 2022.

Full validation results for the 2022 FIDE SNP PIPs are described in **Section III: Validation of Performance Improvement Projects** of this report.

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

1. **Access to and Availability of PCP Services (Non-Clinical PIP) – (4 MCOs – AvDC, HNJTC, UHCDCO, and WCDL)**
   - April 2022 Project Update Submission – Project Status Report through March 2022 -Year 2
   - August 2022 Project Status Reports Submission – Project Year 1 and Project Year 2 Update
2. **Access to and Availability of PCP Services (Non-Clinical PIP) – (1 MCO – AAPP started one year later)**
   - August 2022 Project Update Submission- Project Status and Baseline Update Year 1
3. **Diabetes Management (3 MCOs – AvDC, HNJTC and WCDL)**
   - April 2022 Project Update Submission – Project Status Report through March 2022 – Year 2
   - August 2022 Project Status Reports Submission – Project Year 1 and Project Year 2 Update
4. **Management of Hypertension (1 MCOs – UHCDCO)**
   - April 2022 Project Update Submission – Project Status Report through March 2022 – Year 2
5. **Management of Hypertension (1 MCO – AAPP started one year later)**
   - August 2022 Project Status and Baseline Update – Project Year 1 Update

Comprehensive Administrative Review (2022 Annual Assessment of MCO Operations)

The Annual Assessment of FIDE SNP/Managed Long-Term Services and Supports (MLTSS) Operations is designed to assist with validating, quantifying, and monitoring the quality of each FIDE SNP's structure, processes, and the outcomes of its operations. Effective January 1, 2016, the MLTSS population was included in the FIDE SNP product and Home and Community-Based Services (HCBS) were fully included in the FIDE SNP benefits (nursing facility [NF] was included effective January 2015); this audit period was January 2021–December 2021 for FIDE SNP/MLTSS. FIDE SNPs are subject to annual assessment of operations every 3 years.

AvDC, HNJTC, UHCDCO and WCDL were subject to a partial annual assessment of operations review in the current review period (January 2021–December 2021). Since Aetna Assure Premier Plus (AAPP) joined the New Jersey FIDE SNP network on January 1, 2021, the MCO was subject to a full assessment of operations in 2022.

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 January 1, 2021–December 31, 2021, Four of five MCOs, (AvDC, HNJTC, UHCDCO, and WCDL) scored above NJ's minimum threshold of 85%. One MCO* (AAPP) did not score above the NJ minimum threshold and was subject to Corrective Active Plan (CAP) for those deficient categories.

For AAPP, due to the inadequacy of the documentation provided and the inconsistencies in information provided during the interviews, the External Quality Review Organization (EQRO) (IPRO) was unable to evaluate the following categories: *Access, Quality Assessment and Performance Improvement, Quality Management, Programs for the Elderly and Disabled, and Credentialing and Re-credentialing* for these categories. In these categories, the MCO received a score of 0%, therefore, these scores were removed from the MCO average calculation in those categories.

In 2022, the average compliance score for three (3) standards (Access, Care Management and Continuity of Care, and Administration and Operations) showed increases ranging from 2 to 4 percentage points. In 2022, five (5) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, Care Management and Continuity of Care, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for five (5) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, Enrollee Rights and Responsibilities, Credentialing and Recredentialing, Management Information Systems) remained the same from 2021 to 2022. Four (4) standards (Quality Management, Committee Structure, Provider Training and Performance, and Utilization Management) had decreases ranging from 1 to 7 percentage points in 2022. In 2022, Access had the lowest average compliance score at 85%. Findings from this review can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations** of this report.

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of each MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these eleven (11) standards be evaluated. **Table 1** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards. Of the 220 elements reviewed in 2021 and 222 elements reviewed in 2022 during the Annual Assessments, 81 crosswalk to the CMS QAPI Standards.

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

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[1]
Availability of services	438.206	1 – Access (A), 2 – Credentialing and Re-Credentialing (CR), 3 – Administration and Operations (AO)	A3, A4a–f, A7, CR7, CR8, AO1, AO2	1 – 2019–2020 and 2021–2022 2- 2019–2020 and 2021–2022 3 – 2019–2020 and 2021–2022
Assurances of adequate capacity and services	438.207	1 – Access (A)	A4	1 – 2019–2020 and 2021–2022

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[1]
Coordination and continuity of care	438.208	1 – Care Management and Continuity of Care (CM)	CM2, CM7–CM11, CM14, CM26, CM29, CM34, CM38	1 – 2019–2020 and 2021–2022
Coverage and authorization of service	438.210	1 – Utilization Management (UM)	UM3, UM11, UM14–UM16, UM16o1 UM16o2	1– 2019–2020 and 2021–2022
Provider selection	438.214	1 – Credentialing and Re-Credentialing (CR) 2 – Care Management and Continuity of Care (CM)	CR2, CR3, CM27	1– 2019–2020 and 2021–2022 2 – 2019–2020 and 2021–2022
Confidentiality	438.224	1 – Provider Training and Performance (PT)	PT9	1 – 2019–2020 and 2021–2022
Grievance and appeal systems	438.228	1 – Utilization Management (UM) and Quality Management (QM)	UM16k–n, QM5	1– 2019–2020 and 2021N2022
Subcontractual relationships and delegation	438.230	1 – Administration and Operations (AO)	AO5, AO8–AO11	1– 2019–2020 and 2021–2022
Practice guidelines	438.236	1 – QAPI (Q), 2 – Quality Management QM), 3 – Programs for the Elderly and Disabled (ED)	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1– 2019–2020 and 2021–2022 2 –2019–2020 and 2021–2022 3– 2019–2020 and 2021–2022
Health information systems	438.242	1 – Management Information Systems (IS)	IS1–IS17	1– 2019–2020 and 2021–2022
Quality assessment and performance improvement (QAPI)	438.330	1 – Quality Assessment and Performance Improvement (QAPI) (Q)	Q1–Q3, Q5–Q9	1–2019–2020 and 2021–2022

[1] Within a 3-year cycle, all four MCO's (AvDC, HNJTC, UHCDCO and WCDL) had a full compliance review in 2019 and 2021. In 2022, Aetna participated in a full compliance review, and four MCOs (AvDC, HNJTC, UHCDCO and WCDL) had a partial compliance review. DMAHS requires specific elements to be reviewed annually.

MY 2021 FIDE SNP Performance Measures

For measurement year (MY) 2021 (Healthcare Effectiveness Data and Information Set [HEDIS®] MY 2021), MCOs reported the 13 FIDE SNP HEDIS measures required by CMS. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate the measures. Medication Reconciliation Post Discharge was retired for MY 2021. It is collected as a submeasure of Transitions of Care (TRC). Results of this review can be found in **Section V: Validation of Performance Measures** of this report.

Strengths

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

- Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
- Pharmacotherapy Management of COPD Exacerbation (PCE) [Bronchodilator]

Opportunities for Improvement

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

- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Dementia + Tricyclic Antidepressants or Anticholinergic Agents, Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs, Total]
- Use of High-Risk Medications in the Elderly (DAE)
- Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Falls + Tricyclic Antidepressants or Antipsychotics]
- Colorectal Cancer Screening (COL)
- Pharmacotherapy Management of COPD Exacerbation (PCE) [Systemic Corticosteroid]
- Controlling Blood Pressure (CBP)
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
- Antidepressant Medication Management (AMM) [Effective Acute Phase Treatment]
- Transitions of Care (TRC) [Notification of Inpatient Admission, Medication Reconciliation Post-Discharge, Patient Engagement After Inpatient Discharge, Receipt of Discharge Information]

2020 Information Systems Capabilities Assessments

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

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

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

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

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

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

Quality of Care Surveys

Member Satisfaction – 2022 FIDE SNP CAHPS Survey

IPRO subcontracted with a certified survey vendor to field the CAHPS survey for the FIDE SNP population. Surveys were fielded in spring 2022 for members enrolled in from July 1, 2021, through December 31, 2021. Five FIDE SNP MCO adult surveys were fielded. A total random sample of 7,633 cases was drawn from adult enrollees from the five NJ FIDE SNP plans (AAPP, AvDC, HNJTC, UHCDCO and WCDL); this consisted of a random sample of 1,755 AvDC enrollees, 1,755 HNJTC enrollees, 1,755 UHCDCO enrollees, 1,755 WCDL enrollees, and 613 AAPP enrollees.

During 2022, a Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.1H survey for NJ FIDE SNP enrollees was conducted to assess consumers' experiences with their health plan. The NJ FIDE SNP adult survey project consisted of 40 core questions and 11 supplemental questions. Five FIDE SNPs namely Aetna Assure Premier Plus (AAPP), Amerivantage Dual Coordination (AvDC), Horizon NJ TotalCare (HNJTC), UnitedHealthcare Dual Complete ONE (UHCDCO), and WellCare Dual Liberty (WCDL) participated in the FIDE SNP Program in 2022.

Results from the CAHPS 5.1H survey for NJ FIDE SNP enrollees provided a comprehensive tool for assessing consumers' experiences with their health plan. Complete interviews were obtained from 2,556 NJ FIDE SNP enrollees, and the NJ FIDE SNP response rate was 34.2%. For each of the four domains of member experience (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), a composite score was calculated. The composite scores give a summary assessment of how the plans performed across each domain. The overall composite scores for AAPP, AvDC, HNJTC, UHCDCO and WCDL were as follows: 92.4% for How Well Doctors Communicate; 91.3% for Customer Service; 82.7% for Getting Care Needed; and 80.8% for Getting Care Quickly. Details on these surveys can be found in the **Section VI: Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey**.

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. Results of this review can be found in **Section IX: Encounter Data Validation**.

Conclusion and Recommendations

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

II. New Jersey FIDE SNP/MLTSS Program

FIDE SNP/MLTSS in New Jersey

The BBA of 1997 established that state agencies contracting with (MCOs provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCOs. In accordance with the BBA of 1997 (Subpart E, 42 CFR Section 438.350), an EQRO sets forth the requirements for annual EQR of contracted MCOs. CFR 438.350 requires states to contract with an EQRO to perform an annual EQR of each MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by CMS.

To meet these federal requirements, DMAHS has contracted with IPRO to conduct EQR activities on behalf of DMAHS for the FIDE SNP/MLTSS program. IPRO assesses FIDE SNP operations and performance on key activities and provides recommendations on how these activities can improve the timeliness, quality, and access to healthcare services for enrollees. This report is the result of IPRO's assessment and review of FIDE SNP activities for calendar year 2021.

The FIDE SNP program, administered by DMAHS, provides comprehensive health services to beneficiaries who are eligible for Medicare Part A and B or are enrolled in Medicare Part C and who are also eligible for Medicaid benefits. As of December 2022, there were approximately 78,818 individuals enrolled in AAPP, AvDC, HNJTC, UHCDCO and WCDL (**Table 2**).

Table 2 shows percentages enrollment by plan resulting an increase of 20.12% for the comparative year.

Table 2: 2021–2022 FIDE SNP Enrollment

FIDE SNP	Acronym	Enrollment as of December 2021	Enrollment as of December 2022	Enrollment Percentage Change (+/-)
Aetna Assure Premier Plus[1]	AAPP	1,060	2,270	+114.1%
Amerivantage Dual Coordination	AvDC	12,925	16,108	+24.63%
Horizon NJ TotalCare	HNJTC	16,638	18,926	+13.75%
UnitedHealthcare Dual Complete ONE	UHCDCO	28,450	33,833	+18.92%
WellCare Dual Liberty	WCDL	6,544	7,681	+17.37%
Total		**65,617**	**78,818**	**+20.12%**

Source: DMAHS

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

Figure 1 is a graphic depiction of the size of each FIDE SNP's enrolled population in December 2021 and December 2022 in relation to the total.

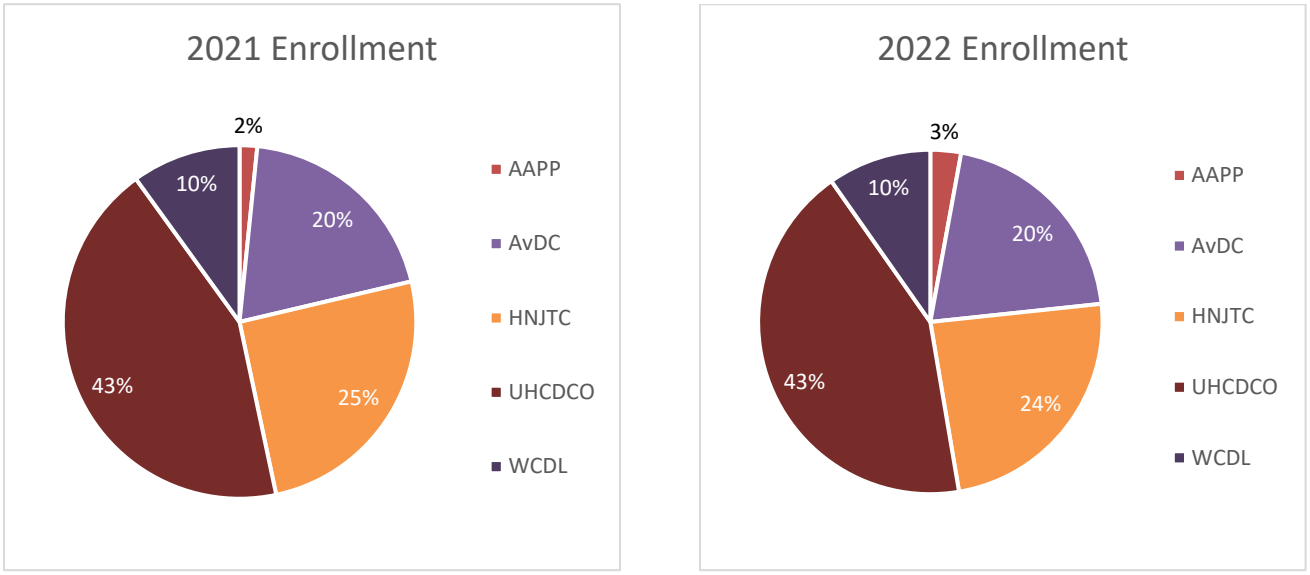

Figure 1: 2021 and 2022 Enrollment Percentages by FIDE SNP Proportion of FIDE SNP enrollment in December 2021 and December 2022 for each FIDE SNP MCOs: brown: Aetna Assure Premier Plus (AAPP) joined the Network on 1/1/2021; purple: Amerivantage Dual Coordination (AvDC); orange: Horizon NJ TotalCare (HNJTC); burgundy: UnitedHealthcare Dual Complete ONE (UHCDCO); and blue: WellCare Dual Liberty (WCDL).

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

Table 3: 2022 EQR Activities by MCO

MCO	FIDE SNP PIPs	PMs	Annual Assessment of MCO Operations	Focus Quality Studies	CAHPS Surveys	ISCA Assessments
AAPP	√	√	√	-	√	√
AvDC	√	√	√	-	√	√
HNJTC	√	√	√	-	√	√
UHCDCO	√	√	√	-	√	√
WCDL	√	√	√	-	√	√

EQR: external quality review; MCO: managed care organization; PM: performance measure; PIP: performance improvement project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; ISCA: Information Systems Capabilities Assessment (conducted in 2022).

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 4**, the state has further identified 24 metrics to track progress towards the three goals listed above.

Table 4: 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	Management Audits	EQRO	85%
		Autism service utilization	Measures in development	TBD

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
	1.3: Support independence for all older adults and people with disabilities who need help with daily activities	MLTSS Care Management Audits	EQRO	86%
		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. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols.

On June 22, 2022, IPRO conducted the annual PIP training for the MCOs. The training (held via virtual platform due to COVID-19), focused on PIP Development, Implementation, Interventions, and current PIP issues. The MCOs will continue to submit project updates in April and August progress reports each year.

Specific MCO PIP topics are displayed in **Table 5**.

Table 5: MCO PIP Topics

MCO	MCO PIP Title(s)[1]	State Topic
Aetna Assure Premier Plus (AAPP)	PIP 1: Improving Access and Availability to Primary Care for the FIDE SNP Population	**Access and Availability (Non-Clinical)**
	PIP 2: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes	**Hypertension (HTN) PIP**
Amerivantage Dual Coordination (AvDC)	PIP 1: Increasing Primary Care (PCP) Access and Availability for Amerigroup Members	**Access and Availability (Non-Clinical)**
	PIP 2: Enhancing Education for Providers and Diabetic Members with Uncontrolled Diabetes (FIDE SNP)	**Diabetes Management**
Horizon NJ TotalCare (HNJTC)	PIP 1: Increasing PCP Access and Availability for Members with High Ed Utilization – Horizon NJ Total Care (FIDE SNP Membership)	**Access and Availability (Non-Clinical)**
	PIP 2: Diabetes Management	**Diabetes Management**

UnitedHealthcare Dual Complete ONE (UHCDCO)	PIP 1: Decrease Emergency Room Utilization for Low Acuity Primary Care Conditions and ~~Improving Access to Primary Care for Adult DSNP (FIDE SNP)~~	**Access and Availability**
	PIP 2: Promoting Adherence to Rein Angiotensin (RAS) Antagonist Hypertensive Medication (FIDE SNP)	**Hypertension (HTN) PIP**
WellCare Liberty (WCDL)	PIP 1: FIDE SNP Primary Care Physician Access and Availability	**Access and Availability**
	PIP 2: Promote Effective Management of Diabetes in the FIDE SNP Population	**Diabetes Management**

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Review Element 6: Results Table:
- Data Collection

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

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

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. Specific to New Jersey, each PIP is then scored based on the MCO's compliance with elements 1–8 (listed above). The element is determined to be "met," "partial met" or "not met. "Compliance levels are assigned based on the number of points (or percentage score) achieved. **Table 6** displays the compliance levels and their applicable score ranges.

Table 6: PIP Validation Scoring and Compliance Levels

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

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

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO reviewed the submission reports and provided scoring and suggestions to the MCOs to enhance their studies. IPRO reviewed the 2022 August Clinical and Non-Clinical PIPs for the five FIDE SNP MCOs (**Table 7–9**).

Table 7: PIP State Topic #1: Access and Availability

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	**IPRO 2022 Scoring** **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP YR 1	**AvDC YR 2**	**HNJTC YR 2**	**UHCDCO YR 2**	**WCDL YR 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	PM	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	PM	M	M	M
Element 1 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP YR 1	**AvDC YR 2**	**HNJTC YR 2**	**UHCDCO YR 2**	**WCDL YR 2**
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	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	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	N/A	M	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	M	M	M	PM	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**PM**	**M**	**PM**	**M**
Element 3 Overall Score	**100**	**50**	**100**	**50**	**100**
Element 3 Weighted Score	**15.0**	**7.5**	**15.0**	**7.5**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data (“5 Why’s”, fishbone diagram)	M	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

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP YR 1	**AvDC YR 2**	**HNJTC YR 2**	**UHCDCO YR 2**	**WCDL YR 2**
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	PM	PM	PM
Element 5 Overall Review Determination	**PM**	**PM**	**PM**	**PM**	**PM**
Element 5 Overall Score	**50**	**50**	**50**	**50**	**50**
Element 5 Weighted Score	**7.5**	**7.5**	**7.5**	**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	M	PM	M	M	M
Element 6 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
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

New Jersey MCO PIP Scoring Report FIDE SNP Access and Availability	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP YR 1	AvDC YR 2	HNJTC YR 2	UHCDCO YR 2	WCDL YR 2
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated, and addressed	**N**	**N**	**N**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**72.5**	**57.5**	**72.5**	**65.0**	**72.5**
Validation Rating Percent	**90.6**	**71.9%**	**90.6%**	**81.3%**	**90.6%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**Moderate**	**High**	**Moderate**	**High**

Scoring will occur in Measurement Year 1
Element 8 is not scored (N/A) 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 #2: Diabetes Management

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP	AvDC YR 2	HNJTC YR 2	UHCDCO [1]	WCDL YR 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	0	PM	M	0	M
1b. Impacts the maximum proportion of members that is feasible	0	M	M	0	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	0	M	M	0	M
1d. Reflects high-volume or high risk-conditions	0	M	M	0	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	0	M	M	0	M
Element 1 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 1 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 1 Weighted Score	**0.0**	**2.5**	**5.0**	**0.0**	**5.0**

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP	**AvDC YR 2**	**HNJTC YR 2**	**UHCDCO** [1]	**WCDL YR 2**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	0	M	M	0	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	0	M	M	0	M
2c. Objectives align aim and goals with interventions	0	M	M	0	M
Element 2 Overall Review Determination	**0**	**M**	**M**	**0**	**M**
Element 2 Overall Score	**0**	**100**	**100**	**0**	**100**
Element 2 Weighted Score	**0.0**	**5.0**	**5.0**	**0.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	0	M	M	0	M
3b. Performance indicators are measured consistently over time	0	M	M	0	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	0	M	M	0	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	0	M	M	0	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	0	M	M	0	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	0	M	M	0	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	0	M	M	0	M
3h. Study design specifies data analysis procedures with a corresponding timeline	0	M	M	0	M
Element 3 Overall Review Determination	**0**	**M**	**M**	**0**	**M**
Element 3 Overall Score	**0**	**100**	**100**	**0**	**100**
Element 3 Weighted Score	**0.0**	**15.0**	**15.0**	**0.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	0	M	M	0	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	0	M	M	0	M

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP	AvDC YR 2	HNJTC YR 2	UHCDCO [1]	WCDL YR 2
4c. Provider input at focus groups and/or Quality Meetings	0	M	M	0	M
4d. QI Process data ("5 Why's", fishbone diagram)	0	PM	M	0	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	0	M	M	0	M
4f. Literature review	0	M	M	0	M
Element 4 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 4 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 4 Weighted Score	**0.0**	**7.5**	**15.0**	**0.0**	**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	0	M	M	0	M
5b. Actions that target member, provider and MCO	0	M	M	0	M
5c. New or enhanced, starting after baseline year	0	M	M	0	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	0	PM	M	0	PM
Element 5 Overall Review Determination	**0**	**PM**	**M**	**0**	**PM**
Element 5 Overall Score	**0**	**50**	**100**	**0**	**50**
Element 5 Weighted Score	**0.0**	**7.5**	**15.0**	**0.0**	**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	0	PM	M	0	M
Element 6 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 6 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 6 Weighted Score	**0.0**	**2.5**	**5.0**	**0.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	0	M	M	0	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	0	PM	M	0	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	0	M	M	0	M
7d. Lessons learned & follow-up activities planned as a result	0	M	M	0	M
Element 7 Overall Review Determination	**0**	**PM**	**M**	**0**	**M**
Element 7 Overall Score	**0**	**50**	**100**	**0**	**100**
Element 7 Weighted Score	**0.0**	**10.0**	**20.0**	**0.0**	**20.0**

New Jersey MCO PIP Scoring Report Diabetes Management	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP	AvDC YR 2	HNJTC YR 2	UHCDCO [1]	WCDL YR 2
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	0	N/A	N/A	0	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	0	N/A	N/A	0	N/A
Element 8 Overall Review Determination	**0**	**N/A**	**N/A**	**0**	**N/A**
Element 8 Overall Score	**0**	**N/A**	**N/A**	**0**	**N/A**
Element 8 Weighted Score	**0.0**	**N/A**	**N/A**	**0.0**	**N/A**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed	N/A	N	N	N/A	N

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**0**	**80**
Actual Weighted Total Score	**0.0**	**50**	**80.0**	**0.0**	**72.50**
Validation Rating Percent	**0%**	**62.5%**	**100.0%**	**0%**	**90.6%**
Validation Status	**No**	**Yes**	**Yes**	**No**	**Yes**
Validation Rating	**N/A**	**Moderate**	**High**	**N/A**	**High**

AAPP and UHCDOC do not have DM PIPs at this time

Element 8 is not scored (N/A) 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 #3: Hypertension Management

Management of Hypertension	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP YR 1	AvDC	HNJTC	UHCDCO YR 2	WCDL
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	0	0	M	0
1b. Impacts the maximum proportion of members that is feasible	M	0	0	M	0
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	0	0	M	0
1d. Reflects high-volume or high risk-conditions	M	0	0	M	0
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	0	0	M	0
Element 1 Overall Review Determination	**M**	**0**	**0**	**M**	**0**

Management of Hypertension	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP YR 1	**AvDC**	**HNJTC**	**UHCDCO YR 2**	**WCDL**
Element 1 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 1 Weighted Score	**5.0**	**0.0**	**0.0**	**5.0**	**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	M	0	0	M	0
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	0	0	M	0
2c. Objectives align aim and goals with interventions	M	0	0	M	0
Element 2 Overall Review Determination	**M**	**0**	**0**	**M**	**0**
Element 2 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 2 Weighted Score	**5.0**	**0.0**	**0.0**	**5.0**	**0.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	0	0	M	0
3b. Performance indicators are measured consistently over time	M	0	0	M	0
3c. Performance Indicators measure changes in health status, functional status, satisfaction, or processes of care with strong associations with improved outcomes	M	0	0	M	0
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	0	0	M	0
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	0	0	M	0
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	0	0	M	0
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	0	0	M	0
3h. Study design specifies data analysis procedures with a corresponding timeline	M	0	0	M	0
Element 3 Overall Review Determination	**M**	**0**	**0**	**M**	**0**
Element 3 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 3 Weighted Score	**15.0**	**0.0**	**0.0**	**15.0**	**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	M	0	0	M	0
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	0	0	M	0
4c. Provider input at focus groups and/or Quality Meetings	M	0	0	M	0

Management of Hypertension	IPRO 2022 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	AAPP YR 1	**AvDC**	**HNJTC**	**UHCDCO YR 2**	**WCDL**
4d. QI Process data ("5 Why's", fishbone diagram)	M	0	0	M	0
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	0	0	M	0
4f. Literature review	M	0	0	M	0
Element 4 Overall Review Determination	**M**	**0**	**0**	**M**	**0**
Element 4 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 4 Weighted Score	**15.0**	**0.0**	**0.0**	**15.0**	**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	M	0	0	M	0
5b. Actions that target member, provider and MCO	M	0	0	M	0
5c. New or enhanced, starting after baseline year	M	0	0	M	0
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	0	0	M	0
Element 5 Overall Review Determination	**PM**	**0**	**0**	**M**	**0**
Element 5 Overall Score	**50**	**0**	**0**	**100**	**0**
Element 5 Weighted Score	**7.5**	**0.0**	**0.0**	**15.0**	**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	M	0	0	M	0
Element 6 Overall Review Determination	**M**	**0**	**0**	**M**	**0**
Element 6 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 6 Weighted Score	**5.0**	**0.0**	**0.0**	**5.0**	**0.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	0	0	M	0
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	0	0	M	0
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	0	0	M	0
7d. Lessons learned & follow-up activities planned as a result	M	0	0	M	0
Element 7 Overall Review Determination	**M**	**0**	**0**	**M**	**0**
Element 7 Overall Score	**100**	**0**	**0**	**100**	**0**
Element 7 Weighted Score	**20.0**	**0.0**	**0.0**	**20.0**	**0.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	0	0	N/A	0
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	0	0	N/A	0
Element 8 Overall Review Determination	**N/A**	**0**	**0**	**N/A**	**0**
Element 8 Overall Score	**N/A**	**0**	**0**	**N/A**	**0**

Management of Hypertension	IPRO 2022 Scoring M=Met PM=Partially Met NM=Not Met				
	AAPP YR 1	AvDC	HNJTC	UHCDCO YR 2	WCDL
Element 8 Weighted Score	**N/A**	**0.0**	**0.0**	**N/A**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated, and addressed	**N**	**N/A**	**N/A**	**N**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**0**	**0**	**80**	**0**
Actual Weighted Total Score	**72.5**	**0.0**	**0.0**	**80.0**	**0.0**
Validation Rating Percent	**90.6%**	**0%**	**0%**	**100.0%**	**0%**
Validation Status	**Yes**	**No**	**No**	**Yes**	**No**
Validation Rating	**High**	**N/A**	**N/A**	**High**	**N/A**

Only two (2) MCOs have a Hypertension Management PIP (AAPP AND UHCDCO)
Element 8 is not scored (N/A) during measurement years 1 and 2
≥ 85% met; 60–84% partial met (corrective action plan); <60% not met (corrective action plan)

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

Table 10: MCO FIDE SNP PIP Validation Results – 2022

MCO Compliance Level	PIP 1 Access & Availability	PIP 2 Diabetes Management	PIP 3 HTN Management
AAPP	90.6%		90.6%
AvDC	71.9%	62.5%	
HNJTC	90.6%	100%	
UHCDCO	81.3%		100%
WCDL	90.6%	90.6%	

Strengths

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

Opportunities for Improvement

- AvDC – The MCO should review all sections of the PIP prior to each submission thereby ensuring the accuracy of the PIP for each submission, review and adjust to align the Barrier Analysis with the Quarterly Reporting metrics and timelines.
- UHCDCO – The MCO should review and address all concerns related to the study design specified data collection methodologies that are valid and reliable, and representative of the entire eligible population, with corresponding timelines with clarifications and/or adjustments for a well-developed PIP that demonstrates the projected impact on the performance outcomes.

PIP Interventions Summary for Each FIDE SNP MCO

Table 11–13 detail PIP interventions for each FIDE SNP MCO.

Table 11: PIP Interventions Summary 2022 for Access and Availability

PIP	Interventions
AAPP – Improving Access and Availability to Primary Care for the FIDE SNP Population	**1. New Member Roster to Targeted PCPs** -Plan to provide 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.
	2. ER Notification to Targeted PCPs – Plan to provide monthly list of members who were seen in the ER with a LANE diagnosis, diagnosis, date of ER visit, and date of last PCP visit. 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.
	3. Practice Transformation Appt. Scheduling – Plan to survey and work with targeted practices 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.
	4. Practice Transformation After Hours Access -Plan to survey and work with targeted practices to review and modify after hours triage, as appropriate. Discussion to occur on quarterly basis with Provider/Practice Manager.
	5. 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.
	6. **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 Nurseline (Informed Nurse Line). Monitor distribution and subsequent ER visits >14 days post mailing. **24-Hour Nurse Line** (Informed Nurse Line) – Educate members (via flyer) assigned to targeted PCPs regarding availability of a "24-Hour Nurse Line" and monitor utilization on a quarterly basis.
	7. IVR Survey – 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.
AvDC - Increasing Primary Care Physician (PCP) Access and Availability for Amerivantage Members	**1. Calls made** to Amerigroup FIDE DSNP members with high emergency room utilization and low PCP visits to determine barriers to care. **Member will be given** educational materials on My HomeDoc for awareness of having needs met in the home
	2. Calls made to providers to determine access barriers, long hold times, after hour availability, provider call availability. **Post visit surveys** sent to Amerigroup FIDE DSNP members to identify barriers to care.
	3. Calls made to Amerigroup FIDE DSNP members with high emergency room utilization admissions to educate members on telemedicine options.

PIP	Interventions
HNJTC - Increasing PCP Access and Availability for members with High ED Utilization Horizon NJ Total Care (FIDE SNP) Membership	**1. Educational materials** mailed to any members that experience an 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, hours of operation, information regarding telemedicine and urgent care alternatives, importance of annual visits, including preventive health screenings and immunizations. Education would also include when and when not to utilize the ED. **FIDE SNP members associated** with the participating providers sites that are enrolled into level 2 and 3 case management that experienced an ER visit and have not had a PCP visit within that last 12 months will be outreached to telephonically by the FIDE SNP CM team to discuss the importance of preventative health visits and how to schedule an appointment with their PCP and when to utilize the ED if needed.
	2. 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. **Monthly list sent** to providers in participating practice groups of auto-assigned members that have not been seen by the provider within 12 months.
UHCDCO – Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult DSNP Members	**1. Contact** Newark Community Health Centers, Rhomur Medical Services, and Forest Hills Family Health Associates adult DSNP 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.
	2. Assist in scheduling an appointment with PCP for the adult DSNP members assigned to Newark Community Health Centers, Rhomur Medical Services and Forest Hills Family Health Associates who had an avoidable ED visit in the past quarter and are overdue for their annual physical.
	3. If the Newark Community Health Center, Rhomur Medical Services, and Forest Hills adult DSNP member indicates lack of transportation as a barrier to visiting the PCP office, educate them on medical transportation benefits offered by Medicaid.
	4. Work collaboratively with identified practices to increase and monitor urgent appointment availability in order to reduce avoidable ED utilization.
	5. Refer adult DSNP 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) to UHCCP Case Management department for evaluation for services.
WCDL – FIDE SNP Primary Care Physician Access and Availability	**1. Implementation** of member education materials for members assigned to PCPs included in the cohort: **- Develop** and distribute member education materials on conditions that can be seen by a PCP versus the Emergency Room or Urgent Care Center. **- Frequency** of distribution; Bi-annually member data will be refreshed to determine if the member who received member education material have seen their PCP instead of Emergency Room or Urgent Care Center for non-emergent reasons. **- 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.
	2. Implementation of provider outreach to update their demographic profile; confirming current availability, document, and track /trend.
	3. Ensure providers are aware that their patients have been utilizing care in a setting other than their office by: Review of High ED Utilizer report, educate providers quarterly on Access & Availability Standards for Emergency Care.

Table 12: PIP Interventions Summary 2022 for Management of Diabetes

PIP	Interventions
AAPP – does not have a Diabetes Management PIP at this time	**N/A**
AvDC - Enhancing Education for Providers and Diabetic Members with Uncontrolled Diabetes	**1a**: **Member will be given** transportation information and connected to the transportation phone number if needed. **1b**: **If member does not want** to go to the Drs. office to have A1C completed- information will be given to provider to facilitate home lab draw.
	2: **Member will be given** educational materials on Diabetic control and nutritional guidance.
	3: Provide education to providers regarding clinical practice guidelines and HEDIS measure focused on A1C control. Share with providers their testing and control non-compliant members.
HNJTC – (FIDE SNP) PIP - Diabetes Management	**1. Care managers will assist** the member in obtaining a blood pressure cuff from OTC vendor (level 2 and level 3 members). Care managers will provide education for monitoring and checking blood pressure. OTC vendor will provide a report on # of BP cuffs ordered per quarter.
	2. Care managers will utilize the care gaps dashboard to identify members that have not had a Diabetic Retinal Exam (DRE). Care managers would outreach to those members and work with them to find an eye doctor, schedule an exam and provide education on the importance of eye exams and diabetes. Care managers will also receive a report from vendor to identify the number of eye exams completed.
	3. Care managers will work with members to make sure that they have a working glucometer and strips.
	4. Care managers will identify members that have an HbA1C >9.0%. They will provide outreach to these members and help them coordinate an appointment with endocrinology. They will also track the subsequent appointments completed (through claims) each quarter.
	5. Care managers will identify members that have not had an HbA1C test in the last 12 months. Care managers will reach out to these members and provide education on the importance of routine HbA1c testing. Care managers will monitor these members to see if they completed the HbA1C test after outreach.
	6. Care managers will identify members that did not have medical attention for nephropathy in the monthly feed from the HEDIS vendor. Care managers will provide outreach and education to these members and subsequently follow-up to see if the member had the follow-up visit.
UHCDCO – does not have a Diabetes Management PIP at this time	**N/A**
WCDL – Promote Effective Management of Diabetes in the FIDE SNP Population	**1. Implementation** of member education materials for members assigned to PCPs included in the cohort: -**Develop** and distribute member education materials on conditions that can be seen by a PCP versus the Emergency Room or Urgent Care Center. -**Frequency** of distribution; Bi-annually member data will be refreshed to determine if the member who received member education material have seen their PCP instead of Emergency Room or Urgent Care Center for non-emergent reasons. -**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.
	2. Implementation of provider outreach to update their demographic profile; confirming current availability, document, and track /trend.
	3. Ensure providers are aware that their patients have been utilizing care in a setting other than their office by: Review of High ED Utilizer report, educate providers quarterly on Access & Availability Standards for Emergency Care.

Table 13: PIP Interventions Summary 2022 for Management of Hypertension

PIP	Interventions
AAPP – Promote the Effective Management of Hypertension to Improve Care and Health Outcomes	**1. Revised CM Workflow**- Incorporate into the CM workflow to complete the condition specific assessment for those members who are diagnosed with hypertension. **Member Education** – Provide education specific to hypertension utilizing Krame's material.
	2. For those members diagnosed with hypertension and no current bp reading documented in care plan, reach out to physician for most recent measurement. **For those members** with no current reading, reach out to member and encourage getting their blood pressure checked. CM can facilitate a PCP follow-up appointment or source to obtain readings.
	3. Member of the care team to manually outreach to provider when no claims data for current BP reading on record for those members who have a diagnosis of hypertension within the previous quarter. **Identify members** who have a BP reading >140/90 and notify provider for further management.
AvDC -Does not have a Hypertension PIP at this time.	**N/A**
HNJTC – Does not have a Hypertension PIP at this time.	**N/A**
UHCDCO – Promoting Adherence to Renin Angiotensin (RAS) Antagonists Hypertensive Medications	**1. Outreach by the pharmacy** team to the members who are non-adherent with RAS-antagonist medication, in order to educate about medication adherence and assist with medication refills.
	2. Provide non-compliant members who reside in Mercer, Camden, and Cumberland counties with written information about hypertension management and importance of medication adherence.
	3. Provide members who reside in Mercer, Camden, and Cumberland counties and who do not utilize 90-day refills with written information about 90-day refill pharmacy benefit.
	4. Educate RAS Antagonist prescribing providers of the members residing in Mercer, Camden, and Cumberland counties who do not utilize 90-day refills to prescribe 90-day fills to NJUHCCP members.
WCDL – Does not have a Hypertension PIP at this time.	**N/A**

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

Objectives

The Annual Assessment of FIDE SNP/MLTSS Operations is designed to assist with validating, quantifying, and monitoring the quality of each FIDE SNP's structure, processes, and the outcomes of its operations. Starting January 1, 2016, the MLTSS population was included in the FIDE SNP product, and HCBS was fully included in the FIDE SNP benefits (NF was included starting January 2015); FIDE SNPs are subject to an assessment of operations every 3 years. AAPP joined the FIDE SNP network in 2021 and was subject to a full annual assessment of operations review in 2022 for the audit period of January–December 2021.

A full annual assessment review was conducted in calendar year 2021 for four of the five FIDE SNP/MLTSS MCOs. AAPP was not required to participate in an Annual Assessment as they just entered the FIDE SNP network on January 1, 2021. All five FIDE SNP MCOs participated in a FIDE SNP/MLTSS Annual Assessment review in March 2022. Four MCOs participated in partial audit, one MCO, AAPP, participated in a full audit (**Table 14**).

Table 14: 2022 Annual Assessment Type by FIDE SNP/MLTSS

FIDE SNP/MLTSS	Assessment Type
AAPP	Full
AvDC	Partial
HNJTC	Partial
UHCDCO	Partial
WCDL	Partial

During the 2022 FIDE SNP/MLTSS Annual Assessment review, 222 elements were subject to review for all participating FIDE SNP plans. For the 2022 FIDE SNP/MLTSS Annual Assessment, certain MLTSS elements that were previously met in the 2021 Full Core Medicaid/MLTSS annual review were not reviewed again. Those elements were considered 'Not Applicable' for the current Assessment. In 2021, elements UM4 and UM21 were removed from the Utilization Management category by DMAHS. In 2022, two elements (CM32 and CM35) were removed from the Care Management and Continuity of Care category, and four elements (CM14, CM18a, CM18c and CM18d) were added to the Care Management and Continuity of Care category for review.

Pursuant to the release of the updated EQRO Protocols by CMS in 2019, the state requested that IPRO conduct an ISCA review in conjunction with the MCOs' Annual Assessment. Activities and findings for this review are reported separately. Reviews of systems were conducted on the day following the interviews for the 2020 Annual Assessment. IPRO's findings and results of the ISCA reviews can be found in the **Section V: Validation of Performance Measures**.

Technical Methods of Data Collection and Analysis

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

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

documentation, IPRO developed the Annual Assessment of FIDE SNP/MLTSS Operations Review Worksheet. This document closely follows the FIDE SNP/State contract and was developed to assess FIDE SNP compliance. Each element is numbered and organized by general topic (e.g., Access, QAPI, Care Management and Continuity of Care, Enrollee Rights and Responsibilities) and includes the contract reference. The worksheet was provided to the plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was calendar year 2021.

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

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

Description of Data Obtained

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

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

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

As a result of the completed process, each reviewed element received a compliance score of Met, Not Met, or Not Applicable. Elements that IPRO designated Not Met also received specific recommendations to help the MCO understand the actions needed to promote compliance in the future. Even high performing organizations can continue to grow and improve. As part of the assessment, IPRO also identified opportunities for

improvement (quality improvement suggestions) that had no bearing on overall MCO compliance but could be considered as part of a broader effort towards continuous quality improvement (CQI).

The standard designations and assigned points used are shown in **Table 15.**

Table 15: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation

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

Conclusions and Comparative Findings

As part of the FIDE SNP/MLTSS Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these eleven (11) standards be evaluated. **Table 16** provides a crosswalk of individual elements reviewed during the FIDE SNP/MLTSS Annual Assessment to the CMS QAPI Standards.

Table 16: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standard

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

Subpart D and QAPI Standards	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[1]
Coverage and authorization of service	438.210	1 – Utilization Management (UM)	UM3, UM11, UM14–UM16, UM16o1 UM16o2	1– 2019–2020 and 2021–2022
Provider selection	438.214	1 – Credentialing and Re-Credentialing (CR) 2 – Care Management and Continuity of Care (CM)	CR2, CR3, CM27	1– 2019–2020 and 2021–2022 2 – 2019–2020 and 2021–2022
Confidentiality	438.224	1 – Provider Training and Performance (PT)	PT9	1 – 2019–2020 and 2021–2022
Grievance and appeal systems	438.228	1 – Utilization Management (UM) and Quality Management (QM)	UM16k–n, QM5	1– 2019–2020 and 2021N2022
Subcontractual relationships and delegation	438.230	1 – Administration and Operations (AO)	AO5, AO8–AO11	1– 2019–2020 and 2021–2022
Practice guidelines	438.236	1 – QAPI (Q), 2 – Quality Management QM), 3 – Programs for the Elderly and Disabled (ED)	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1– 2019–2020 and 2021–2022 2 –2019–2020 and 2021–2022 3– 2019–2020 and 2021–2022
Health information systems	438.242	1 – Management Information Systems (IS)	IS1–IS17	1– 2019–2020 and 2021–2022
Quality assessment and performance improvement (QAPI)	438.330	1 – Quality Assessment and Performance Improvement (QAPI) (Q)	Q1–Q3, Q5–Q9	1–2019–2020 and 2021–2022

[1] Within a 3-year cycle, four MCO's (AvDC, HNJTC, UHCDCO and WCDL) had a full compliance review in 2019 and 2021. In 2022, Aetna participated in a full compliance review, and four MCOs (AvDC, HNJTC, UHCDCO and WCDL) had a partial compliance review. DMAHS requires specific elements to be reviewed annually.

Of the 222 elements reviewed during the 2022 FIDE SNP/MLTSS Annual Assessments, 73 elements crosswalk to the eleven (11) CMS QAPI Standards. **Table 17** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI Standards identified by CMS.

Table 17: Subpart D and QAPI Standards – Scores by MCO

Subpart D and QAPI Standard	CFR Citation	AA Review Elements	# of Elements Reviewed	AAPP	AvDC	HNJTC	UHCDCO	WCDL
Availability of services	438.206	A3, A4a–f, A7, CR7, CR8, AO1, AO2	12	17%	83%	83%	58%	75%
Assurances of adequate capacity and services	438.207	A4	1	0%	100%	100%	100%	100%
Coordination and continuity of care	438.208	CM2, CM14, CM29, CM34, CM38	5	100%	100%	100%	100%	100%

Subpart D and QAPI Standard	CFR Citation	AA Review Elements	# of Elements Reviewed	AAPP	AvDC	HNJTC	UHCDCO	WCDL
Coverage and authorization of services	438.210	UM3, UM11, UM14–UM16, UM16o1 UM16o2	7	86%	100%	100%	100%	100%
Provider selection	438.214	CR2, CR3	2	0%	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16k.1, UM16k.2, UM16l.1, UM16l.2, UM16m.1, UM16m.2, UM16n.1, UM16n.2, QM5	9	89%	100%	100%	100%	89%
Subcontractual relationships and delegation	438.230	AO5, AO8–AO11	5	100%	100%	100%	100%	100%
Practice guidelines	438.236	Q4, QM1, QM3, ED3, ED10, ED23, ED29	7	0%	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, Q2, Q5–Q9	7	0%	100%	100%	100%	100%
Total Elements Reviewed			**73**					
Compliance Percentage				**54%**	**98%**	**98%**	**96%**	**97%**

All five (5) MCOs participated in the 2022 Compliance Review. A total of 222 elements were reviewed by each MCO for a total of 888 elements reviewed overall. Four (4) of the five (5) participating FIDE SNP MCOs showed strong performance in the CMS Subpart D and QAPI Standards ranging from 96% to 98% compliance (**Table 17).**

Three of the five MCOs received 100% compliance for 10 of the 11 standard domains. Four of the five MCOs received 100% compliance in 8 of 11 standard domains. All five (5) MCOs were non-compliant in Availability of Services (**Table 17**). One MCO (AAPP) was non-compliant in 5 of 11 standard domains.

Table 18 displays a comparison of the overall compliance score for each of the five participating MCOs from 2021 and 2022. For the review period January 1, 2022 – December 31, 2022, AvDC, HNJTC, UHCDCO and WCDL scored above NJ's minimum threshold of 85% **(Table 18).** The 2022 compliance scores from the Annual Assessment ranged from 51% to 99% in 2022; UHCDCO's compliance score increased from 94% to 97%; AvDC and HNJTC's compliance scores increased 1 percentage point to 99%; and WCDL's compliance score remained unchanged from 2021 at 98% (**Table 18**).

Table 18: Comparison of 2021 and 2022 Compliance Scores by MCO

MCO	2021 Compliance %	2022 Compliance %	% Point Change from 2019 to 2021
AAPP	N/A	51%[1]	N/A
AvDC	98%	99%	+1%
HNJTC	98%	99%	+1%
UHCDCO	94%	97%	+3%
WCDL	98%	98%	0%

[1] For AAPP due to the inadequacy of the documentation provided and the inconsistencies in information provided during the interviews, the External Quality Review Organization (EQRO) (IPRO) was unable to evaluate the following categories: Access, Quality Assessment and Performance Improvement, Quality Management, Programs for the Elderly and Disabled, and Credentialing and Re-credentialing for these categories. In these categories, the MCO received a score of 0%, therefore, these scores were removed from the MCO average calculation in those categories.
N/A: not applicable.

In 2022, the average compliance score for three (3) standards (Access, Care Management and Continuity of Care, and Administration and Operations) showed increases ranging from 2 to 4 percentage points (**Table 19**). In 2022, five (5) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, Care Management and Continuity of Care, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for five (5) standards (Quality Assessment and Performance Improvement, Programs for the Elderly and Disabled, Enrollee Rights and Responsibilities, Credentialing and Recredentialing, Management Information Systems) remained the same from 2021 to 2022 (**Table 19**). Four (4) standards (Quality Management, Committee Structure, Provider Training and Performance, and Utilization Management) had decreases ranging from 1 to 7 percentage points in 2022. In 2022, Access had the lowest average compliance score at 85% (**Table 19**).

Table 19: 2021 and 2022 Compliance Scores by Review Category

Review Category	MCO Average 2021[1]	MCO Average 2022[1, 4]	Percentage Point Change
Access	83%	85%	+2%
Quality Assessment and Performance Improvement	100%	100%	0%
Quality Management	100%	97%	-3%
Committee Structure	100%	93%	-7%
Programs for the Elderly and Disabled	100%	100%	0%
Provider Training and Performance	98%	93%	-5%
Enrollee Rights and Responsibilities	98%	98%	0%
Care Management and Continuity of Care	97%	100%	+3%
Credentialing and Recredentialing	98%	98%	0%
Utilization Management	98%	97%	-1%
Administration and Operations	96%	100%	+4%
Management Information Systems	100%	100%	0%
TOTAL	**97%[2]**	**97%[3]**	0%

[1] FIDE SNP average is calculated as the average of the scores of the FIDE SNPs for each review category.
[2] Total is the average of compliance scores for four (4) of the five (5) MCOs listed in **Table 17**.
[3] Total is the average of compliance scores for five (5) MCOs listed in **Table 17**.
[4] For AAPP, due to the inadequacy of the documentation provided and the inconsistencies in information provided during the interviews, the External Quality Review Organization (EQRO) (IPRO) was unable to evaluate the following categories: Access, Quality Assessment and Performance Improvement, Quality Management, Programs for the Elderly and Disabled, and Credentialing and Re-

credentialing for these categories. In these categories, the MCO received a score of 0%, therefore, these scores were removed from the MCO average calculation in those categories.

Appendix: 2022 FIDE SNP-Specific Review Findings contains detailed information on each FIDE SNP's Annual Assessment.

FIDE SNP Strengths

Some of the most notable FIDE SNP strengths identified as a result of the 2022 Annual Assessment of FIDE SNP/MLTSS Operations are:

- The implementation and evaluation of a comprehensive Quality Management Program that meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing quality improvement activities and demonstrates ongoing initiatives.
- All four MCOs continue to perform at 100% compliance with regard to Quality Assessment and Performance Improvement (QAPI), Programs for the Elderly and Disabled, Care Management and Continuity of Care, Administration and Operations, and Management Information Systems.

Recommendations

Recommendations represent areas of deficiency. Because some recommendations are smaller in scope and impact, for the purposes of this report, IPRO has focused on areas that are the most common across FIDE SNPs and that require follow-up for more than one reporting period.

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

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

V. Validation of Performance Measures

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

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

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

Description of Data Obtained

The five participating FIDE MCOs with performance data for MY 2021 (AAPP, AvDC, HNJTC, UHCDCO and WCDL) 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 20).**

Table 20: MCO Compliance with Information System Standards – MY 2021

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

Information Systems Capabilities Assessments (ISCA)

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

The assessment covered the following areas:

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

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

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

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

IPRO's ISCA 2020 review findings and results by MCO are in **Table 21**.

Table 21: Information Systems Capabilities Assessment (ISCA) Results for 2020

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

[1] Encompasses managed care organizations (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).*
N/A: not applicable.

HEDIS MY 2021 FIDE SNP Performance Measures

IPRO validated the processes used to calculate the 13 HEDIS MY 2021 PMs required by CMS for SNP reporting by the five FIDE SNPs (AAPP, AvDC, HNJTC, UHCDCO, and WCDL). All five FIDE SNP MCOs reported the required measures for MY 2021.

1. Colorectal Cancer Screening (COL)
2. Care for Older Adults (COA)
3. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
4. Pharmacotherapy Management of COPD Exacerbation (PCE)
5. Controlling Blood Pressure (CBP)
6. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

7. Osteoporosis Management in Women Who Had a Fracture (OMW)
8. Antidepressant Medication Management (AMM)
9. Follow-Up After Hospitalization for Mental Illness (FUH)
10. Transitions of Care (TRC)
11. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)
12. Use of High-Risk Medications in the Elderly (DAE)
13. Plan All-Cause Readmissions (PCR)

Table 23 presents the individual FIDE SNP rates for each of the above 13 measures. There are no national benchmarks for the FIDE SNP population. Results for the NJ FIDE SNP average are compared to the National Medicare benchmarks. When interpreting these results, it should be kept in mind that the FIDE SNP population, which is a more vulnerable population, may differ considerably from the Medicare population.

Conclusions and Comparative Findings

In MY 2021, MCOs were required to submit a full set of SNP measures. No year-over-year comparisons are available for Colorectal Cancer Screening (COL), Care for Older Adults (COA), Controlling High Blood Pressure (CBP), Transitions of Care (TRC), Use of High-Risk Medications in the Elderly (DAE) and Plan All-Cause Readmissions (PCR).

Of the seven measures for which year-over-year comparisons were valid, most of the measures remained constant from MY 2020 to MY 2021 (< 5 percentage point change). Significant increases (≥ 5 percentage point change) in performance from MY 2020 are noted below:

1. Improvements in performance from MY 2021:
    - Controlling High Blood Pressure (CBP)
    - Osteoporosis Management in Women Who Had a Fracture (OMW)
    - Antidepressant Medication Management - Effective Continuation Phase Treatment (AMM)

There are no national benchmarks for the FIDE SNP population. Results for the NJ FIDE SNP Average are compared to the National Medicare benchmarks. In interpreting these results, it should be borne in mind that the SNP population, which is a more vulnerable population, may differ considerably from the Medicare population. Also, Plan All-Cause Readmissions (PCR) is a risk-adjusted measure. Calculation of a weighted average for this measure is not appropriate.

1. Rates below the 10th percentile:
    a. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Dementia + Tricyclic Antidepressants or Anticholinergic Agents, Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs, Total]
    b. Use of High-Risk Medications in the Elderly (DAE)
2. Rates between the 10th percentile and the 25th percentile:
    a. Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [Falls + Tricyclic Antidepressants or Antipsychotics]
3. Rates between the 25th percentile and 50th percentile:
    a. Colorectal Cancer Screening (COL)
    b. Pharmacotherapy Management of COPD Exacerbation (PCE) [Systemic Corticosteroid]
    c. Controlling Blood Pressure (CBP)
    d. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
    e. Antidepressant Medication Management (AMM) [Effective Acute Phase Treatment]
    f. Transitions of Care (TRC) [Notification of Inpatient Admission, Medication Reconciliation Post-Discharge, Patient Engagement After Inpatient Discharge, Receipt of Discharge Information]
4. Rates between the 50th percentile and 75th percentile:

a. Antidepressant Medication Management (AMM) [Effective Continuation Phase Treatment]
b. Follow-Up After Hospitalization for Mental Illness (FUH) [7-Day Follow-up, 30-Day Follow-up]

5. Rates above the 75th percentile:
   a. Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
   b. Pharmacotherapy Management of COPD Exacerbation (PCE) [Bronchodilator]

The HEDIS rates are color coded to correspond to National percentiles (**Table 22**).

Table 22: Color Key for HEDIS Performance Measures

Color Key	How Rate Compares to the NCQA HEDIS MY 2021 Quality Compass National Percentiles
Red	Less than 10th Percentile
Orange	Greater than or equal to 10th and 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 Percentile
Purple	No percentiles released by NCQA

HEDIS data presented in this section include: Effectiveness of Care, and Utilization and Risk Adjusted Utilization. **Table 23** displays the HEDIS performance measures for MY 2021 for all MCOs and the New Jersey FIDE SNP Average. The FIDE SNP average is the weighted average of all MCO data.

Table 23: HEDIS MY 2021 FIDE SNP HEDIS Performance Measures

HEDIS MY 2021 FIDE SNP Measures	AAPP	AvDC[1]	HNJTC	UHCDCO	WCDL	Health Plan Average[2]	MY 2021 New Jersey FIDE SNP Average[3]
Colorectal Cancer Screening (COL) – Hybrid Measure [4]	N/A	60.72%	51.34%	75.43%	58.15%	61.41%	65.56%
Care for Older Adults (COA) – Hybrid Measure [5]							
Advance Care Planning	17.84%	29.60%	78.72%	62.04%	43.07%	46.25%	57.92%
Medication Review	99.59%	99.51%	84.46%	89.54%	93.43%	93.31%	90.59%
Functional Status Assessment	57.68%	59.59%	80.41%	73.71%	58.64%	66.01%	71.07%
Pain Screening	68.88%	91.97%	92.57%	91.00%	93.92%	87.67%	91.71%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	N/A	28.38%	30.65%	37.92%	31.43%	32.10%	33.98%
Pharmacotherapy Management of COPD Exacerbation (PCE)							
Systemic Corticosteroid	N/A	68.83%	72.58%	68.35%	65.91%	68.92%	69.80%
Bronchodilator	N/A	90.91%	91.61%	88.01%	90.91%	90.36%	90.15%

HEDIS MY 2021 FIDE SNP Measures	AAPP	AvDC[1]	HNJTC	UHCDCO	WCDL	Health Plan Average[2]	MY 2021 New Jersey FIDE SNP Average[3]
Controlling High Blood Pressure (CBP) – Hybrid Measure [4]	48.44%	42.64%	68.86%	76.16%	71.29%	61.48%	68.01%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	N/A	N/A	N/A	86.54%	N/A	86.54%	88.46%
Osteoporosis Management in Women Who Had a Fracture (OMW)	N/A	N/A	25.81%	55.56%	N/A	40.69%	35.40%
Antidepressant Medication Management (AMM)							
Effective Acute Phase Treatment	N/A	85.28%	72.66%	76.77%	75.38%	77.52%	77.49%
Effective Continuation Phase Treatment	N/A	80.28%	63.31%	59.71%	56.15%	64.86%	64.84%
Follow-Up After Hospitalization for Mental Illness (FUH)							
30-Day Follow-Up	N/A	47.93%	47.22%	46.93%	46.32%	47.10%	47.73%
7-Day Follow-Up	N/A	30.34%	29.37%	25.24%	32.63%	29.40%	28.64%
Transitions of Care (TRC) – Hybrid Measure [6]							
Notification of Inpatient Admission	0.00%	0.00%	7.06%	3.65%	12.17%	4.58%	4.64%
Medication Reconciliation Post-Discharge	50.61%	47.45%	68.61%	47.45%	45.01%	51.83%	53.32%
Patient Engagement After Inpatient Discharge	70.12%	71.87%	88.08%	77.13%	79.56%	77.35%	79.26%
Receipt of Discharge Information	0.00%	0.00%	9.00%	3.41%	4.87%	3.46%	4.44%
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [6]							
Falls + Tricyclic Antidepressants or Antipsychotics	N/A	39.00%	41.44%	40.82%	45.95%	41.80%	41.06%
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	N/A	51.97%	49.49%	56.17%	55.66%	53.32%	53.96%
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	N/A	18.31%	15.79%	17.88%	21.78%	18.44%	17.82%
Total	N/A	43.49%	40.41%	45.38%	49.42%	44.67%	44.46%

HEDIS MY 2021 FIDE SNP Measures	AAPP	AvDC[1]	HNJTC	UHCDCO	WCDL	Health Plan Average[2]	MY 2021 New Jersey FIDE SNP Average[3]
Use of High-Risk Medications in the Elderly (DAE) [6]	N/A	26.06%	24.76%	28.37%	29.08%	27.07%	27.21%
Plan All-Cause Readmissions (PCR) [6,7,8]							
18-64 year olds, Observed-to-expected Ratio	N/A	1.3521	1.4801	1.2655	1.0016		
65+ year olds, Observed-to-expected Ratio	N/A	1.1795	1.3353	1.2932	1.0513		

Note: Submission of Hybrid measures was not required for MY 2021.

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

[2] Health plan average uses only MCOs who had an eligible population greater than or equal to 30.

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

[4] Amerigroup reported this measure administratively.

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

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

[7] PCR is a risk-adjusted measure. Calculation of MCO and statewide averages is not appropriate.

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

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

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

Objectives

IPRO subcontracted with a certified survey vendor to field the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey (5.1H) for the FIDE SNP population. Surveys were fielded in spring 2022 for members enrolled in from July 1, 2021 through December 31, 2021. Five FIDE SNP adult surveys were fielded.

Technical Methods of Data Collection and Analysis

The CAHPS survey drew, as potential respondents, FIDE SNP adult enrollees over the age of 18 years who were covered by NJ FamilyCare; enrollees had to be continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Respondents were surveyed in English and Spanish. The surveys were administered over a 10-week period from April 1, 2022 through June 15, 2022, using a standardized survey procedure and questionnaire. A total random sample of 7,633 cases was drawn from adult enrollees from the five NJ FIDE SNP MCOs (AAPP, AvDC, HNJTC, UHCDCO and WCDL); this consisted of a random sample of 1,755 AVDC enrollees, 1,755 HNJTC enrollees, 1,755 UHCDCO enrollees, 1,755 WCDL enrollees, and 613 AAPP enrollees.

Results from the CAHPS 5.1H survey for NJ FIDE SNP enrollees provided a comprehensive tool for assessing consumers' experiences with their health plan. The instrument selected for the survey was the HEDIS-CAHPS 5.1H FIDE SNP Survey for use in assessing the performance of health plans. The survey instrument used for the NJ FIDE SNP survey project consisted of 40 core questions and 11 supplemental questions.

The CAHPS rates are color coded to correspond to the National percentiles as shown in **Table 24**.

Table 24: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2020 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2021 Quality Compass National Percentiles
Orange	Below the national Medicaid 25th percentile
Yellow	Between the national Medicaid 25th and 50th percentiles
Green	Between the national Medicaid 50th and 75th percentiles
Blue	Between the national Medicaid 75th and 90th percentiles
Purple	Above the national Medicaid 90th percentile

Description of Data Obtained and Conclusion

Complete interviews were obtained from 2,556 NJ FIDE SNP enrollees, and the NJ FIDE SNP response rate was 34.2%. For each of four domains of member experience (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), a composite score was calculated. The composite scores give a summary assessment of how the MCOs performed across each domain. The overall composite scores for AAPP, AvDC, HNJTC, UHCDCO and WCDL were:

- 82.7% for Getting Needed Care;
- 80.8% for Getting Care Quickly;
- 92.4% for How Well Doctors Communicate; and
- 91.3% for Customer Service (**Table 25**).

The New Jersey FIDE SNP product is a joint Medicaid/Medicare program. The comparisons in **Table 25** rank responses for the FIDE SNP membership against National Medicaid responses. Overall, New Jersey MCOs showed a high level of member satisfaction in the MY 2021 FIDE SNP CAHPS surveys. Weighted statewide average rates ranked at or above the NCQA national 50th percentile for seven (7) of the eight (8) adult survey measures. How Well Doctors Communicate ranked between the national Medicaid 25th and 50th percentiles. Opportunities for improvement are evident for two (2) MCOs (AAPP and WCDL) with rates below the 25th percentile for Getting Needed Care (AAPP and WCDL), Getting Care Quickly (WCDL), Customer Service (AAPP), Rating of All Health Care (AAPP and WCDL), and Rating of Specialist Seen Most Often (AAPP).

Table 25: CAHPS MY 2021 Performance – FIDE SNP Survey

FIDE SNP Adult Survey – CAHPS Measure	AAPP	AvDC	HNJTC	UHCCDCO	WCDL	Statewide Weighted Average
Getting Needed Care	78.0%	84.6%	84.4%	82.0%	78.0%	82.7%
Getting Care Quickly	86.9%	82.7%	81.1%	80.9%	75.1%	80.8%
How Well Doctors Communicate	92.6%	92.3%	91.3%	93.0%	92.6%	92.4%
Customer Service	85.4%	90.3%	93.6%	91.3%	86.8%	91.3%
Rating of All Health Care[1]	72.4%	78.1%	77.1%	76.8%	67.2%	76.3%
Rating of Personal Doctor[1]	86.0%	86.6%	84.9%	87.1%	86.3%	86.3%
Rating of Specialist Seen Most Often[1]	79.1%	89.5%	87.2%	84.4%	81.9%	85.8%
Rating of Health Plan[1]	75.5%	85.2%	87.2%	86.1%	81.3%	85.6%

[1] For this measure, Medicaid rate is based on survey scores of 8, 9 and 10.

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

VII. Encounter Data Validation

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

VIII. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Tables 26–30** display the participating FIDE SNP MCOs' responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

AAPP – Response to Previous EQR Recommendations

Table 26 display's AAPP's progress related to the *State of New Jersey DMAHS, Amerivantage Dual Coordination Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of AAPP's response.

Table 26: AAPP – Response to Previous EQR Recommendations

Recommendation for AAPP	AAPP Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should ensure that the template format is correct to safeguard the accuracy of data reporting remains consistent year over year. The MCO should review and clarify data definitions for accurate and consistency.	The MCO will review and ensure that the state-mandated template is used consistently without changes for all PIP submissions. All key health plan staff attended the 2022 annual DMAHS Performance Improvement Project training session which will help ensure that correct templates are consistently used, and state processes are followed. The MCO has received and reviewed the November 2021 IPRO PIP recommendations. The MCO is reviewing the submitted data definitions from the 2021 PIP project proposals. The MCO will make any required adjustments to ensure data definitions are clear, accurate and consistent.	Addressed

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

AvDC – Response to Previous EQR Recommendations

Table 27 display's AvDC's progress related to the *State of New Jersey DMAHS, Horizon New Jersey TotalCare Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of AvDC's response.

Table 27: AvDC – Response to Previous EQR Recommendations

Recommendation for AvDC	AvDC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should update the alignment of barriers, interventions, and ITMs clearly and consistently across PIP tables from the proposal	Throughout the life of the PIP, interventions are identified and updated based on several factors. As we identify barriers expressed from members, we create interventions to address them. We ensure that the interventions address the barriers by having clear and concise methods for improvement. As additional interventions are identified, they are added to any barrier they may address. For example, the utilization of My HomeDoc addresses barriers related to access of care, transportation, and A1C compliance. When updating PIPs, we ensure that the interventions are aligned with all associated barriers to specifically address	Addressed

Recommendation for AvDC	AvDC Response/Actions Taken	IPRO Assessment of MCO Response[1]
throughout the life of the PIP. This information should include formatting conventions (to better facilitate interpretation of the reported information and appropriately evaluate the PIP progress).	each need. Each barrier and associated intervention are discussed in detail within the results to show improvement achieved or continued areas of concern if no progress is noted.	
The MCO should continue to address access deficiencies in specialty providers in Atlantic County for oral surgeons and in Cape May County for oral surgeons and psychiatrists.	Amerigroup's 2Q2022 DSNP GEO access report reflects 100% network adequacy in Cape May County for Psychiatry. LIBERTY's dental network for Amerigroup FIDE members is 100% compliant for Time and Distance GeoAccess Standards. There are over 20 oral surgery points of access throughout the southern portion of New Jersey which provides coverage for members within Cape May and Atlantic Counties.	Addressed
The MCO should continue to address deficiencies in MLTSS social day providers in Salem and Warren Counties.	Amerigroup's 2Q2022 DSNP GEO access report for MLTSS reflects 2 providers in Salem and 3 providers in Warren. In addition, we are continuing 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.	Addressed
The MCO should continue to address appointment availability for adult PCPs, OB/GYNs, and behavioral health providers, as well as deficiencies in after-hours compliance	We continue to publish the Appointment Availability and After-Hours Standards via provider newsletters. We also discuss with providers during regularly scheduled meetings. We conduct surveys yearly in June with results usually coming back a couple of months later. For any provider who did not meet the standard during survey, a Corrective Action Plan (CAP) letter is sent to them. Provider Experience team will follow up with these providers to ensure we receive CAP letter back from the provider and that it addresses the issue.	Addressed
The MCO should be able to provide all relevant job descriptions noted in the contract language.	We will complete an annual review of the required job descriptions and have them readily available for audit.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA	To ensure we are continually monitoring measures that fell below benchmark, we utilize tools to assist with identifying barriers our members have reported. With the recent implementation of post visit surveys, we can identify barriers to access of care. From this, our interventions are	Addressed

Recommendation for AvDC	AvDC Response/Actions Taken	IPRO Assessment of MCO Response[1]
national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	based on the needs of the members. These interventions can demonstrate improvement in performance as evidenced by members receiving the needed care, having educational materials, and having additional resources to assist with meeting needs.	
The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	As we continue to work towards improving CAHPS scores that perform below the 50th percentile, we are utilizing areas of low performance to identify barriers of care and interventions for improvement. In our efforts, we are identifying service and provider gap areas which result in low access to care for members. While addressing service and provider gaps, we are also evaluating to ensure that we have the appropriate providers, specialists, and pharmacies available to our members. We are continuing to assist members with issues as they arise and making attempts to prevent additional issues. By identifying barriers and implementing interventions, we hope to reduce the occurrence of low preforming scores. We are attempting to ensure that members have an ease of understanding their benefits and the methods of using them.	Addressed

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

HNJTC – Response to Previous EQR Recommendations

Table 28 display's HNJTC's progress related to the *State of New Jersey DMAHS, Horizon New Jersey TotalCare Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of HNJTC's response.

Table 28: HNJTC – Response to Previous EQR Recommendations

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should review the PIPs Barrier Analysis, Interventions, and Intervention Tracking measures to ensure alignment between each table inclusive of start and end dates of	Horizon will continue to utilize a multi-tiered review process for all PIP submissions with the intent of identifying and correcting inconsistencies between data tables and report sections, inclusive of start and end dates of interventions. Moving forward, Horizon will focus on assuring that there is alignment between the Barrier Analysis, Interventions and the Tracking Measures on all submitted PIPs, and that revisions are noted in the Change Table when applicable.	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
interventions thereby ensuring the duration of intervention's importance for evaluating the strength of association of a given intervention on the performance indicators for a given measurement period.		
The MCO should continue to address hospital deficiencies Warren County.	Horizon has contracted with Hackettstown Medical Center on 4/1/21, which eliminated the hospital deficiency in Warren County.	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to expand the MLTSS network to include at least two providers in every county for assisted living and social day care. The MCO should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers	There are a limited number of Social Adult 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 partner 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 help expand the MLTSS Social Adult Day Care network. Information has been sent to facilities in these counties to begin the credentialing process: **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 expanded the network in that county. Bayonne AMDC (Hudson County) and Prestige of Marlton (Burlington County) agreed to become participating providers, which would assist in expanding the network in those counties. Horizon continues to outreach and negotiate contracts to meet deficient coverage areas. As for assisted living facilities, there are limited recruiting opportunities due to a lack of licensed providers in New Jersey. Horizon was able to successfully contract with VCare Assisted Living on 1/1/2022 to provide services in Gloucester and Salem Counties. Horizon will continue recruitment of assisted living providers to join the network when licensed facilities are identified.	Addressed
The MCO should address urgent care appointment availability with medical specialists	Horizon is actively addressing urgent care appointment availability with providers. Education surrounding urgent care appointments is being provided via monthly webinars, articles in the Provider Pulse Newsletter (published three times per year) as well as telephone outreach education that is conducted for the providers who were non-compliant with the Appointment Availability standards. The telephone outreach, which began in Q2, 2022, consists of one on one education with providers that is specific to those standards where they were non-compliant. Three outreach attempts are made in an effort to complete the education with providers after their CAP is received.	Addressed
The MCO should continue to address deficiencies in after-hour access for PCPs, specifically with regard to call-back times (15-minute call-back time for	Horizon continues to address deficiencies in after-hours access for PCPs. Due to staff shortages and transitioning back into offices post-COVID, plans continue to be faced with an industry challenge for this standard. Recognizing the importance of this standard, Horizon has established a multifaceted effort to work with our network and bring them into compliance with this requirement. These efforts include: 1) Providing education to all providers on 24 hour access standards. Education includes information in our monthly webinars, articles in our	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
emergent care and call back within 45 minutes).	Provider Pulse Newsletter (published three times per year) and Provider Portal News alerts. In Q3, 2022, Horizon also began telephone outreach to offices that are non-compliant with the standards. This includes information on call back times. 2) Providers that fail an audit (including dental providers) receive education during the audit, written notification and must submit a corrective action plan. 3) Additional follow up is done to ensure provider office procedures are updated 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 to re-educate them on the standards. This one on one training began in Q3, 2022. 4) Beginning in Q4 2022 and continuing into 2023, educational outreach will be included in our large groups that already have quarterly meetings with Internal Horizon staff (such as Value Based Groups). 5) The Appointment Availability and 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 address dental provider availability for routine, urgent and emergency appointments.	It was identified that dental offices were not meeting appointment availability standards due to CDC guidance regarding COVID-19 guidelines regarding social distancing. Due to the pandemic, offices are no longer double booking in an effort to avoid a full waiting room. They are also scheduling longer appointments to perform more treatments at one time, and require more time in between appointments for sanitation. There has been a significant improvement over the past several months, and as of Quarter 2, 2022 the goals for appointment availability have been met. Access to emergency and urgent dental appointments met at 98%, and access to routine care met at 89%.	Addressed
The MCO should ensure that FIDE SNP UM notification letters are sent timely and documented in the files.	A root cause analysis was conducted by the Utilization Management Team to determine the reason authorization approval letters were not auto generated when authorization determinations were made. Although infrequent, it was identified that system issues can prevent approval letters from auto-generating. In July 2020, approval letters were added to the daily missing letter report that captures authorizations in which the UM letters to the member and/or provider were not generated. The report is monitored daily and actions are taken to re-trigger the letter. An Authorization Turn-around-Time report is monitored daily to ensure authorizations are made within required timeframes. A monthly Turn-around-Time report is also assessed to identify trends and actions are implemented as necessary. The Managed Care Coordinator's (MCC) monthly quality audit tool was updated in August 2020 to monitor staff adherence to accurate authorization classifications. Re-training in correct event classification was conducted for the MCC team in August 2020 and with all new hires going forward.	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should ensure that MLTSS UM provider and member letters are sent timely and documented in the files.	A root cause analysis was conducted by the Utilization Management Team to determine the reason authorization approval letters were not auto generated when authorization determinations were made. Although infrequent, it was identified that system issues can prevent approval letters from auto-generating. In July 2020, approval letters were added to the daily missing letter report that captures authorizations in which the UM letters to the member and/or provider were not generated. The report is monitored daily and actions are taken to re-trigger the letter. An Authorization Turn-around-Time report is monitored daily to ensure authorizations are made within required timeframes. A monthly Turn-around-Time report is also assessed to identify trends and actions are implemented as necessary. The Managed Care Coordinator's (MCC) monthly quality audit tool was updated in August 2020 to monitor staff adherence to accurate authorization classifications. Re-training in correct event classification was conducted for the MCC team in August 2020 and with all new hires going forward.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	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. Several departments across HNJH work collaboratively to impact performance for low performing measures including the Quality Management, Case management, Pharmacy and Behavioral Health teams. In 2022, several initiatives are underway to improve HEDIS measure performance: - Member Rewards program continues to incentivize members that completed an Annual Wellness visit, Colorectal Cancer Screening, Breast Cancer Screening, Diabetes Eye exam and Bone Mass Density Testing - An Interactive Voice Recognition campaign was implemented and member mailers were sent to educate members on preventive screenings, diabetes care and to remind them of the annual flu vaccine - Ongoing partnership with Magellan, a vendor that is currently contracted for Statin therapy for patients with cardiovascular disease, will be contracted for the Osteoporosis Management in Women (OMW) measure to improve performance (the contract is under DMAHS review) - The Results and Recognition Program (R&R) has assigned a Clinical Quality Improvement Liaison to each provider site in the program, and is accountable for sharing provider gap reports on a regular basis. Live webinars are also held quarterly for providers, educating them on various measures. The R&R program provides several resources to the provider through the Quality Resource Center including billing tip sheets, HEDIS Guidelines, the Provider Manual and recorded webinars. The efforts are aimed at provider and plan collaboration to improve HEDIS results.	Addressed

Recommendation for HNJTC	HNJTC Response/Actions Taken	IPRO Assessment of MCO Response[1]
	- HNHJ's 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 has developed and implemented member educational mailers for select measures.	
The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	The Quality Management (QM) Team has been working very closely with the FIDE SNP Case Management (CM), Member Experience 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 now 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. The FIDE SNP CM team has also implemented multiple programs to provide additional support to members. The team has collaborated with Mom's Meals to provide healthy meals to members who have been discharged from an inpatient facility. The team has partnered with Bayada Home Care in a pilot program to provide home nursing visits to targeted members to assist with CAHPS getting needed care, getting care quickly, care coordination and closing care gaps. The QM, Member Experience and 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 the overall member experience. 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.	Addressed

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

UHCDCO – Response to Previous EQR Recommendations

Table 29 display's UHCDCO's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Dual Complete ONE Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of UHCDCO's response.

Table 29: UHCDCO – Response to Previous EQR Recommendations

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO might consider	The following 2 FIDE SNP PIPs collaborated with Providers to support the Aim of the PIPS.	Addressed

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
collaboration with the Provider groups to increase support of the PIP and potentially enhance outcomes.	New Jersey UnitedHealthcare Community Plan (NJUHCCP) UnitedHealthcare Dual Complete® ONE (HMO D-SNP Promoting Adherence to Renin Angiotensin System (RAS) Antagonist Hypertensive Medications; The PIP's aim is to increase adherence to the Hypertension medications. Studies indicate that members who have a 90-day supply or mail order improve their adherence. The PIP identifies the Providers who prescribe RAS-antagonist medications in less than 90-day supply. Collaboration to educate these providers on the 90-day retail and mail-order pharmacy benefit occurs on a quarterly basis. New Jersey United Healthcare Community Plan (NJUHCCP) United Health Dual Complete® ONE (HMO D-SNP Decreasing Emergency Utilization for Low Acuity Primary Care conditions and Improving Access to Primary Care for Adult DSNP Members; The MCO collaborated with the following Provider Practices: Newark Community Health Centers, Rhomur Medical Services, Forest Hills Family Health Associates. The MCO conducted quarterly meetings with these Provider Practices' leadership to reduce avoidable ED utilization and increase access to primary care. The MCO was involved in discussion regarding the MCO outreach to the practices' members who utilized the Emergency Room. the PIP progress and reviewed the updates regarding the practices' appointment access.	
The MCO should continue to monitor the pediatric PCP network in Morris County.	UHCCPNJ no longer has a pediatric PCP deficiency in Morris County for FIDE SNP as of June 2021 network deficiency reporting, and there hasn't been a deficiency in this specialty since, as of the June 2022 network deficiency reporting.	Addressed
The MCO should continue to monitor the specialty providers network in Atlantic, Burlington, Camden, Cumberland, Gloucester, and Salem Counties. Per-case agreements should be established to ensure access to acute care hospitals where appropriate.	UHCCPNJ monitors all specialty provider deficiencies on a quarterly basis. The specialty that had deficiencies in Atlantic, Burlington, Camden, Cumberland, Gloucester, and Salem counties were for Prosthodontics per the December 2020 network deficiency reporting. These deficiencies have since been remediated as of March 2021 reporting, as of the June 2022 network deficiency reporting. Single case agreements can be arranged for members to receive care from an out-of-network provider, when medically necessary.	Addressed
The MCO should continue to monitor the hospital network in Salem and Cumberland Counties. Per-case agreements should be established to ensure access to	UHCCPNJ monitors network deficiencies on a quarterly basis, including the hospital network. The Network Contracting team is still in negotiation phases to fill network adequacy for members in Salem County. 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 Cumberland County. This would reflect in future provider network reporting.	Addressed

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
acute care hospitals where appropriate.		
The MCO should continue to monitor the MLTSS provider network in all counties, with the exception of Camden County. Per-case agreements should be established to ensure access to acute care hospitals where appropriate.	UHCCPNJ monitors network deficiencies on a quarterly basis, including the MLTSS network, and reviews any possible providers to contract or re-contract with to meet the 2 per county, per MLTSS specialty minimum. Single case agreements may be arranged for members to receive scheduled non-emergent care from an out-of-network provider, including acute care hospitals, when medically necessary.	Addressed
The MCO should continue to address appointment availability for OB/Gyns and behavioral health providers.	UHCCPNJ has a process 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.	Addressed
The MCO should develop a "population report" to identify the major population's representative of the plan's membership.	UHCCPNJ runs a semi-annual membership report by county and language. UHCCPNJ also provides real-time membership census reporting by language, aid category and member demographics. Currently and historically, English and Spanish are the only major language populations with over 5% of the plan membership.	Addressed
The MCO should ensure PCP performance indicators are included in the FIDE SNP recredentialing files.	UHCCPNJ continues to review and document the quality metrics, complaints, and quality issues for providers during their recredentialing cycle on the recredentialing checklist and ensure that the recredentialing checklists that is used to review and track the PCP performance indicators are included in all of the applicable files including the FIDE SNP recredentialing files.	Addressed
The MCO should consider including a turnaround time (TAT) column on the blended census report to monitor timely concurrent and extended stay determinations.	UHCCPNJ continues to use the blended census reporting tool (BCRT) to monitor and work IP cases reviewed on a concurrent basis. The BCRT now includes a TAT Met column showing Met/Not Met to meet the external regulators recommendation.	Addressed
The MCO should ensure timely UM	UHCCPNJ continues to utilize reporting mechanisms to support adherence to regulatory requirements. Measures include but are not	Addressed

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
determinations and timely member/provider written notifications.	limited to timeliness of decision making, notification of decisions, communications with contracted providers as applicable, and overall satisfaction with UM processes. When possible, data is collected centrally and systematically from the UM systems. Specific to pre-service HCBS requests, the clinical manager monitors pending requests from a queue, on a daily basis, to ensure compliance with timeliness guidelines.	
The MCO should evaluate relevant policies and procedures annually and ensure that contract requirements related to timely notifications and approvals are included.	UHCCPNJ has procedures 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 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.	Addressed
The MCO should evaluate relevant policies and procedures annually and ensure that contract requirements related to timely notifications regarding significant changes are included.	UHCCPNJ has procedures 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 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.	Addressed
The MCO should provide sample inpatient and discharge plans of	UHCCPNJ Inpatient Care Managers (ICMs) perform a risk stratification tool (RST) for every admission. This tool assists in screening for potential readmissions, complex discharge needs and case management referrals. The Inpatient Care Managers collaborate with	Addressed

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
care, noting how the inpatient CM facilitates coordination and continuity of care throughout the hospital stay and discharge.	the hospital case managers to identify appropriate discharge needs as well as initiate referrals to the care management team if needed or applicable. Discharge Care Managers (DCM) receive referrals from ICM based on designated criteria and are responsible for managing qualified inpatient members for transitions of care and barriers to discharge. When DCMs receive a member referral from ICM, they will conduct hospital case manager outreach to coordinate discharge planning, as well as inpatient member outreach to discuss the discharge plan. They will coordinate with the Facility case manager or social worker to determine member or Authorized Representative availability to complete the discharge planning discussion. DCM identifies any unmet needs or concerns that may increase risk of readmission and assess if the member is appropriate for program referrals. The DCMs document this plan in the case management system (ICUE). For future audits, ICM/DCM will provide case note screenshots evidencing how this is documented in ICUE.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	UHCCPNJ completed a barrier analysis on the low performing FIDE-SNP measures and developed interventions to improve rates with input from key stakeholders including Behavioral Health, Pharmacy and Member Engagement. 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. Performance is monitored on an ongoing basis and shared at various departmental and Quality meetings.	Addressed
The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile	For UHCCPNJ, FIDESNP Members and FIDE SNP Providers are included in the Adult and Child CAHPS surveys and the Interventions in the MEDICAID CAHPS Workplan. The MCO 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	Addressed

Recommendation for UHCDCO	UHCDCO Response/Actions Taken	IPRO Assessment of MCO Response[1]
	interventions/initiatives are completed, evaluated, and continue through 2022/2023.	

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

WCDL – Response to Previous EQR Recommendations

Table 30 displays WCDL's progress related to the *State of New Jersey DMAHS, WellCare Liberty Annual External Quality Review Technical Report FINAL REPORT: April 2022,* as well as IPRO's assessment of WCDL's response.

Table 30: WCDL – Response to Previous EQR Recommendations

Recommendation for WCDL	WCDL Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should define the specific data monitored with clarifications or adjustments for a well-developed PIP that ultimately demonstrates the intended impact on performance outcomes.	WellCare Health Plan Implemented Intervention Tracking Measures (ITMs), to define specific data monitoring activities that allow clear focus on PIP defined objectives and its impact on the identified Performance Indicators. PIP topic, FIDE-SNP Primary Care Physician Access and Availability, the specific data monitoring was clarified with respect to cohorts and Performance Indicators to support the PIP objective to reach WellCare's final goal. 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. Interventions were better defined as either Monthly, Quarterly, or semi-annually. The impact of COVID-19 was also considered and tracked to show data as the situation was 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 for appointments. PIP Topic was identified to promote effective management of diabetes in the FIDE SNP population. Decimal placement and rounding inconsistencies were addressed throughout the PIP data points, and any miscalculations were fixed in order to ensure accuracy of the data results for year over year comparison.	Addressed
The MCO should continue to monitor the hospital network for Bergen and Mercer Counties. Per-case agreements should be established to ensure access to acute care hospitals where appropriate.	Per IPRO's recommendation, WellCare has contracts with all available hospitals in Bergen County. As for Mercer County, WellCare has a contract with Penn Princeton which give us a referral for another Hospital that also covers the deficiency. WellCare has a meeting scheduled with Capital Health in hopes to secure a contract. In the interim, the Plan will provide single case agreements as needed to participating specialists located in other counties and assist members in their transportation needs so they are able to access the care they need.	Addressed
The MCO should continue to recruit for assisted living providers in Camden and Cumberland Counties.	MCO recruitment activities continue throughout the State. Currently, Camden County is at a 100% compliant with network requirements- WellCare has three providers in network within Camden County, Bentley Senior Living Pennsauken PID 1013045, Spring Oak of Voorhees PID 2460287, Villa Raffaella PID 983982.As for Cumberland	Addressed

Recommendation for WCDL	WCDL Response/Actions Taken	IPRO Assessment of MCO Response[1]
	County, The Plan has three contracted facilities. WellCare also has a contract with Spring Oak Assisted Living at Vineland (PID 2434878) while, Baker Place and Maurice House both have declined to contract with the Plan and is only taking private pay. WellCare continues to offer Single Case Agreements as needed.	
The MCO should address after-hours availability with primary care providers.	The Plan continues to address after-hour availability to enhance process. Please see an example below. On 2/10/2022 the Network Team address after-hour concerns by obtaining a list of Providers who failed and provided outreach and education on after-hour best practices. To enhance to process, the tracking tool of failed Providers now sits in a shared location for visibility and access so each network representative could view and update accordingly. 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. As this is a continued intervention, the Plan enhanced this intervention, and added a new step to follow-up with the providers within 90 days after the initial outreach to ensure that the reason they failed has been identified and addressed.	Addressed
The MCO should ensure the correct consent forms are attached to each claim before it is processed.	The Plan address these recommendations on 4/25/2022 with the claims department. Policies and Procedures were updated to include ANES provider specialty, requiring a consent form to be submitted for each claim as prior to this update, these Providers were excluded. Claims for sterilization that do not have a consent form will auto adjudicate to deny. This update also includes verbiage in our step action documents instructing the processors to deny claims if the consent form has not been submitted.	Addressed
The plan should ensure participating providers comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441.	WellCare will be denying claims for sterilization that are sent either electronically or via paper without the consent form attached. As of now, the Network team receives a list of codes on a quarterly basis of any “failed” providers along with the reason (whether they submitted electronically or submitted paper without the required consent form). The health plan tracks and monitors outreach and education on a spreadsheet to ensure all providers have been educated. Additionally, this has been added to our provider onboarding orientation presentation for awareness.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider	WellCare’s goal is to increase HEDIS ® rates to the NCQA 50th percentile requirement or higher. The Plan submits a quality work plan as per contract and State/IPRO request on an annual basis, where clinical performance fell below the NCQA 50th percentile. Planned and ongoing interventions include WellCare to conduct a quality focused provider education visits to providers group practices. These visits focus on educating provider and office manager regarding coding and claims submission, review of Care Gaps for their members. Provider Toolkits, which include information on all HEDIS measures, best	Addressed

Recommendation for WCDL	WCDL Response/Actions Taken	IPRO Assessment of MCO Response[1]
interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	practices guidelines and medical record documentation guidelines are left behind as a resource. Quality team also coordinates efforts to close care gaps, while educating providers on the importance of closing care gaps and assisting provider with care gap reports and any missed opportunities. This process includes reviewing of medical record to identify coding deficiencies and re-educating providers and practice manager on best practices. 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 Provider visits monthly via the QI metric reports. WellCare's Preventive Service Outreach (PSO) program to make outbound calls to non-compliant members for various Medicaid measures to notify and educate them on the importance of preventive services and assist with appointment setting. NJ Quality Improvement's Performance Improvement Team (PIT) Work Group meets on a weekly basis to discuss updated on Project tracking, Current rates, progress on measures, programs & initiatives, and any possible community outreach forms by the health educator on focused HEDIS measures. The meeting invitation is extended to cross-functional departments within the organization for collaboration on quality initiatives.	
The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	WellCare continues to work towards achieving their goal of increasing the FIDE SNP Adult CAHPS rate 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. WellCare of New Jersey has established plans and ongoing interventions to monitoring the process (CAHPS Customer Service calls) in which recorded customer services calls are analyzed and training opportunities for Customer Service rep are identified. The goal here 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. The Quality Team also visits targeted groups & practitioners for education regarding the use of the Provider Portal, Specialist in network, and 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 a user-friendly educational resource that displays HEDIS, CAHPS/HOS and Quality standards in a neatly packaged, color coded folder for practitioners and their staff to use as reference. In addition, the document titled "Coordination of Care" is also included in the Provider toolkit. Phone numbers for Customer Service, Care Management and	Addressed

Recommendation for WCDL	WCDL Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Community Connection are shared with practitioners and staff to strengthen partnership for member care. The CAHPS workgroups is poised to meet regularly and, on an AD-HOC basis to track the Medicaid CAHPS work plan to discuss progress and outcomes.	

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

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

Tables 31–35 highlight each MCO's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of 2021 EQR activities as they relate to **quality**, **timeliness**, and **access**.

AAPP – Strengths and Opportunities for Improvement, and EQR Recommendations

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

Table 31: AAPP – Strengths and Opportunities for Improvement, and EQR Recommendations

Aetna Assure Premium Plus – Strengths, Opportunities for Improvement, and EQR Recommendations[1]		
EQR Activity	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 2 PIPs scored, both PIPs performed at or above the 85% threshold indicating high performance	No opportunities for improvements identified.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, 4 standards received 100% compliance.	Opportunities for improvements were found in seven (7) of 12 categories during the 2022 FIDE SNP/MLTSS compliance review. Five (5) of the seven (7) categories received a score of 0%.
Performance Measures	AAPP reported no (0) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 5 measures/sub-measures reported below the 50th percentile. (Fifteen (15) measures/submeasures were N/A.)
Quality of Care Surveys – Member (CAHPS 2021)	Two (2) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Six (6) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	No recommendations.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access, Quality Assessment and Performance Improvement, Quality Management, Programs for the Elderly and Disabled, and Credentialing and Recredentialing** 1. Due to the inadequacy of the documentation provided and the inconsistencies in information provided during the interviews, the External Quality Review Organization (EQRO) (IPRO) was unable to evaluate and the MCO received a score of 0% for the above 5 categories. DMAHS provided the Corrective Action Plans (CAPs) for these categories. **Committee Structure** 1. CS2: The MCO should ensure that all mortality data are collected, monitored, investigated as appropriate, and aggregated for accurate reporting providing opportunity for education and/or corrective action as needed. 2. CS6: The MCO should ensure that the FIDE SNP population metrics are discussed at the appropriate committee meetings as well as recommendations to improve processes. 3. CS8: The MCO should include and document FIDE SNP members in their MLTSS Consumer Advisory Committee meetings.	

Aetna Assure Premium Plus – Strengths, Opportunities for Improvement, and EQR Recommendations[1]	
	Provider Training and Performance 1. PT1: The MCO should develop a system to track under and over utilization of services. 2. PT1: The MCO should develop provider profiles for all FIDE SNP providers. 3. PT2: The MCO should develop a process to conduct annual Medical Record Reviews (MRRs) in provider offices. 4. PT6: The MCO should develop a system to track providers who attend initial trainings. 5. PT10: The MCO should initiate initial and ongoing training programs for MLTSS providers. **Enrollee Rights and Responsibilities** 1. ER6: The MCO should ensure to include MLTSS member rights and responsibilities in the appropriate policies. **Utilization Management** 1. UM16: The MCO should provide clear and concise descriptions of their processes for grievances and quality of care investigations. These descriptions should delineate the MCO's role in these investigations, including their role in outreach to providers to discuss corrective action plans where appropriate. 2. UM16: The MCO should track date of closure of grievance and quality of care issues for reporting to the state. 3. UM22: The MCO should provide consistent documentation prior to the annual assessment. This documentation should be consistent with the processes described by the MCO staff during the review sessions. 4. UM22: The MCO should provide narratives for all elements that direct the reviewers to the specific documents submitted as evidence of compliance with the Contract. 5. UM24: The MCO should track grievance and quality of care investigations from beginning of the investigation to the date of closure. 6. UM27: The MCO should provide narratives for all elements that direct the reviewers to the specific documents submitted as evidence of compliance with the Contract. 7. UM28: The MCO should provide narratives for all elements that direct the reviewers to the specific documents submitted as evidence of compliance with the Contract. 8. UM30: The MCO should provide narratives for all elements that direct the reviewers to the specific documents submitted as evidence of compliance with the Contract.
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS MY 2021)	The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.

[1] AAPP entered the FIDE SNP market on 1/1/2021.

AvDC – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 32: AvDC – Strengths and Opportunities for Improvement, and EQR Recommendations

AvDC – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	No strengths identified.	The MCO should be mindful of the Aim, Objectives, and Goals and ensure the Methodology/ Interventions are clearly defined, easily understandable and aligns with each subsequent section of the PIP.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, 10 standards received 100% compliance.	Opportunities for improvements were found in Access and Quality Management during the 2022 FIDE SNP/MLTSS compliance review.
Performance Measures	AvDC reported four (4) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 12 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS MY 2021)	Seven (7) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	One (1) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	The MCO should review each section of the PIP to ensure alignment of the Aim, Goals and Objectives are well-defined and aligns with each subsequent section for a well-developed and comprehensive PIP that demonstrates the projected outcomes.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4f. The plan should continue to recruit for Social Adult Day Providers in Cape May, Cumberland, Hunterdon, Ocean, Salem, and Warren Counties. 2. A7. The plan should continue to address appointment availability for OB/GYNs, other specialists, and behavioral health prescribers, as well as deficiencies in after-hours compliance. **Quality Management** 1. QM11. The MCO should be mindful of the Aim, Objectives, and Goals, as well as the impact to the members over the life of the FIDE SNP PIP to monitor ongoing progress. 2. QM11. The MCO should ensure that the FIDE SNP PIP Methodology and Interventions are clearly defined, easily understandable and aligns with each subsequent section of the PIP.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
Quality of Care Surveys – Member (CAHPS MY 2021)	The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	

HNJTC – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 33: HNJTC – Strengths and Opportunities for Improvement, and EQR Recommendations

HNJTC – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 2 PIPs scored, both PIPs performed at or above the 85% threshold indicating high performance.	No opportunities for improvements identified.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, ten (10) standards received 100% compliance.	Opportunities for improvements were found in Access during the 2022 FIDE SNP/MLTSS compliance review.
Performance Measures	HNJTC reported five (5) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 13 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS MY 2021)	Seven (7) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	One (1) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	No recommendations.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4f. The plan should continue to address deficiencies in MLTSS Social Day providers in Atlantic, Bergen, Camden, Essex, Middlesex, Morris, Salem, Summerset, Union, Burlington, Cape May, Hudson, Hunterdon, Monmouth, and Ocean. 2. A7. The plan should continue to address appointment availability for Adult PCPs, Specialists, Behavioral Health, and Dental, as well as deficiencies in after-hours compliance.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
Quality of Care Surveys – Member (CAHPS MY 2021)	The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	

UHCDCO – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 34: UHCDCO – Strengths and Opportunities for Improvement, and EQR Recommendations

UHCDCO – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 2 PIPs scored, one PIP performed at or above the 85% threshold indicating high performance	The MCO should ensure the data reflects the specific diagnoses that are being monitored reflecting why there is opportunity for the members to seek PCP

UHCDCO – Strengths, Opportunities for Improvement, and EQR Recommendations		
		office visits prior to ED utilization as appropriate.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, 10 standards received 100% compliance.	Opportunities for improvements were found in Access, Quality Management and Credentialing and Recredentialing, during the 2022 FIDE SNP/MLTSS compliance review.
Performance Measures	UHCDCO reported four (4) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 11 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS MY 2021)	Seven (7) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	One (1) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	The MCO should review all sections of the PIP to ensure alignment of each section for a well-developed and comprehensive PIP that demonstartes projected outcomes.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4d. The plan should continue to address access deficiencies in Dental providers in Ocean County. 2. A4e. The plan should continue to address Hospital access deficiencies in Salem and Cumberland Counties. 3. A4f. The plan should continue to address deficiencies in MLTSS social day providers in Atlantic, Bergen, Burlington, Cape May, Cumberland, Hudson, Hunterdon, Mercer, Morris, Ocean, Passaic, Salem, Sussex, Union, and Warren Counties. 4. A7. The plan should continue to address appointment availability for adult PCPs, OB/GYNs, and behavioral health providers, as well as deficiencies in after-hours compliance for Dental providers. **Quality Management** 1. QM11. The MCO should ensure that the FIDE SNP PIP's have more than one robust intervention. 2. QM11. The MCO should ensure that all data captured should be updated with corresponding discussion points. 3. QM11. The MCO should ensure that the timeline aligns with the timeline and reporting components of the PIP process. **Credentialing and Recredentialing** 1. CR8. The MCO should ensure that review of PCP performance indicators is included in the FIDE SNP recredentialing process for both directly credentialed and delegated providers. 2. CR8. The MCO should improve its network reporting to accurately reflect provider types and PCP status in reporting.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider	

UHCDCO – Strengths, Opportunities for Improvement, and EQR Recommendations	
	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 MY 2021)	The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.

WCDL – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 35: WCDL – Strengths and Opportunities for Improvement, and EQR Recommendations

WCDL – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
PIPs	Of the 2PIPs scored, both PIPs performed at or above the 85% threshold indicating high performance.	No opportunities for improvements identified.
Compliance with Medicaid and CHIP Managed Care Regulations	Of the 11 quality-related Subpart D and QAPI standard areas reviewed in 2022, nine (9) standards received 100% compliance.	Opportunities for improvements were found in Access and Utilization Management during the 2022 FIDE SNP/MLTSS compliance review.
Performance Measures	WCL reported four (4) measures/sub-measures above the 50th percentile.	Opportunities for improvement were identified for 9 measures/sub-measures reported below the 50th percentile.
Quality of Care Surveys – Member (CAHPS MY 2021)	Two (2) of eight (8) composite FIDE SNP Adult CAHPS measures were above the 50th percentile.	Six (6) of eight (8) composite CAHPS measures for the FIDE SNP survey fell below the 50th percentile.
Recommendations		
PIPs	No recommendations.	
Compliance with Medicaid and CHIP Managed Care Regulations	**Access** 1. A4d. The plan should continue to monitor the dental network for Ocean County. Single case agreements should be established to ensure access to dentists where appropriate. 2. A4f. The plan should continue to recruit for assisted living providers in Salem County and social adult day cares in Cape May, Hunterdon, Salem, Sussex, and Warren Counties. 3. A7. The plan should address after-hours availability with providers. **Utilization Management** 1. UM16n.1. The plan should ensure timely resolution letters are sent for all Provider Appeals.	
Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, the MCO should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
Quality of Care Surveys –	The MCO should continue to work to improve FIDE SNP Adult CAHPS scores that perform below the 50th percentile.	

WCDL – Strengths, Opportunities for Improvement, and EQR Recommendations	
Member (CAHPS MY 2021)	

Appendix A: 2022 FIDE-SNP–Specific Review Findings

Appendix Table of Contents

Aetna Assure Premier Plus (AAPP)

AAPP: 2022 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
							Prior	Resolved	New
Access	19	19	0	19	0	0%	0	0	19
Quality Assessment and Performance Improvement	9	9	0	9	0	0%	0	0	9
Quality Management	14	14	0	14	0	0%	0	0	14
Committee Structure	9	9	6	3	0	67%	0	0	3
Programs for the Elderly and Disabled	43	43	0	43	0	0%	0	0	43
Provider Training and Performance	11	11	7	4	0	64%	0	0	4
Enrollee Rights and Responsibilities	10	10	9	1	0	90%	0	0	1
Care Management and Continuity of Care	11	11	11	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	0	10	0	0%	0	0	10
Utilization Management	44	43	37	6	1	86%	0	0	6
Administration and Operations	20	20	20	0	0	100%	0	0	0
Management Information Systems	22	22	22	0	0	100%	0	0	0
TOTAL	**222**	**221**	**112**	**109**	**1**	**51%**	**0**	**0**	**109**

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

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

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

AAPP Performance Measure Validation – FIDE SNP Measures

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

Findings

- AAPP reported all the required measures for MY 2021.

AAPP MY 2021 FIDE SNP Performance Measures	Rate	Status
Colorectal Cancer Screening (COL) - Hybrid Measure	NA	R
Care for Older Adults (COA) - Hybrid Measure		
Advance Care Planning	17.84%	R
Medication Review	99.59%	R
Functional Status Assessment	57.68%	R
Pain Screening	68.88%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	NA	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	NA	R
Bronchodilator	NA	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	48.44%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	NA	R
Effective Continuation Phase Treatment	NA	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-Up	NA	R
7-Day Follow-Up	NA	R
Transitions of Care (TRC) - Hybrid Measure		
Notification of Inpatient Admission	0.00%	R
Medication Reconciliation Post-Discharge	50.61%	R
Patient Engagement After Inpatient Discharge	70.12%	R
Receipt of Discharge Information	0.00%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [1]		
Falls + Tricyclic Antidepressants or Antipsychotics	NA	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	NA	R
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	NA	R
Total	NA	R
Use of High-Risk Medications in the Elderly (DAE)[1]	NA	R
Plan All-Cause Readmissions (PCR) [1,2,3]		
18-64 year olds, Observed-to-expected Ratio	NA	R
65+ year olds, Observed-to-expected Ratio	NA	R

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

[2]PCR is a risk adjusted measure.

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

R – Reported Rate

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

AAPP: Performance Improvement Projects

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

MCO Name: Aetna Assure Premier Plus (HMO DSNP)

PIP Topic 1: Improving Access and Availability to Primary Care for the FIDE SNP 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	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			
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	N/A	**N**			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**0.0%**	**90.6%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 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 complaint.

Element 5 Overall Review Determination was that the MCO was MCO is partially complaint 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 19, Table 1b, inconsistent decimal rounding notations are used. For example, Yr. 1 Q2 ITM 1b 24/83=29 exhibits rounding up) whereas ITM Yr.1 Q2 1c exhibits 3/24=12.5% (rounding not applied). Additionally,

numerator 0/denominator 2= 0.00%. Additional rounding inconsistencies are noted in Table 1b. Uniform numeric writing conventions are important for consistency and accuracy over the life of the PIP for an effective evaluation of progress.

Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is complaint.
Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at this phase.
Element 9 Overall Review Determination was that Health Disparities were not addressed in this submission.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 75.2 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has updated dated the PIP for the submission noting that baseline data has been updated to 2021, which may identify additional opportunities for the progression of this PIP. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP that is demonstrative of the intended impact on the performance outcomes.

AAPP PIP Topic 2: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes

MCO Name: Aetna Assure Premier Plus (HMO D-SNP)

PIP Topic 2: Promote the Effective Management of Hypertension to Improve Care and Health Outcomes

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= Not Applicable)	**N/A**	**N**			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**0.0%**	**90.6%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: September 22, 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 complaint.

Element 3 Overall Review Determination was that the MCO is complaint.

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

Element 5 Overall Review Determination was that the MCO is partially complaint 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 21-22, Table 1b exhibits multiple variations regarding decimal writing conventions. For example, ITM #1aii Y1Q1 19/68=27.94% whereas Y1Q2 10/21=47% however, equals 47.61%. Throughout Table 1b there are multiple variations of decimal placement or no decimal placement. The MCO should commit to one form of rounding for decimal and whole throughout all numeric data for consistency and accuracy over 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 complaint.

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

Element 9 Overall Review Determination was that Healthcare disparities have not been addressed.

Overall, the MCO was partially 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]). 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. Additionally, the MCO should note page 24, Results should be landscape presentation as per the PIP Template. The MCO should ensure that all changes are noted and documented in the April and August 2023 submissions.

Amerivantage Dual Coordination (AvDC)

AvDC: 2022 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Met Prior Audit	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	19	16	12	17	2	0	89%	2	1	0
Quality Assessment and Performance Improvement	9	9	9	9	0	0	100%	0	0	0
Quality Management	14	14	9	13	1	0	93%	0	0	1
Committee Structure	9	8	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	43	43	10	43	0	0	100%	0	0	0
Provider Training and Performance	11	11	5	11	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	10	10	4	10	0	0	100%	0	0	0
Care Management and Continuity of Care	13	9	6	11	0	2	100%	0	0	0
Credentialing and Recredentialing	10	10	2	10	0	0	100%	0	0	0
Utilization Management	44	41	13	44	0	0	100%	0	0	0
Administration and Operations	20	18	4	20	0	0	100%	0	1	0
Management Information Systems	22	19	0	22	0	0	100%	0	0	0
TOTAL	**224**	**208**	**77**	**219**	**3**	**2**	99%	**2**	**2**	**1**

[1] The MCO was subject to a full review in the previous review period.

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

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

[4] Four (4) additional CM elements were added in 2022 for FIDE SNP only.

AvDC Performance Measure Validation – FIDE SNP Measures

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

Findings

- AvDC reported the required measures for HEDIS MY 2021.

AvDC MY 2021 FIDE SNP Performance Measures	Rate[1]	Status
Colorectal Cancer Screening (COL) - Hybrid Measure [2]	60.72%	R
Care for Older Adults (COA) - Hybrid Measure [3]		
Advance Care Planning	29.60%	R
Medication Review	99.51%	R
Functional Status Assessment	59.59%	R
Pain Screening	91.97%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	28.38%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	68.83%	R
Bronchodilator	90.91%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure [2]	42.64%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	85.28%	R
Effective Continuation Phase Treatment	80.28%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-Up	47.93%	R
7-Day Follow-Up	30.34%	R
Transitions of Care (TRC) - Hybrid Measure		
Notification of Inpatient Admission	0.00%	R
Medication Reconciliation Post-Discharge	47.45%	R
Patient Engagement After Inpatient Discharge	71.87%	R
Receipt of Discharge Information	0.00%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [4]		
Falls + Tricyclic Antidepressants or Antipsychotics	39.00%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	51.97%	R
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	18.31%	R
Total	43.49%	R
Use of High-Risk Medications in the Elderly (DAE)[4]	26.06%	R
Plan All-Cause Readmissions (PCR) [4,5,6]		
18-64 year olds, Observed-to-expected Ratio	1.3521	R
65+ year olds, Observed-to-expected Ratio	1.1795	R

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

[2]Amerigroup reported this measure administratively.

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

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

[5]PCR is a risk adjusted measure.

[6]This measure uses count of index stays as the denominator and an observed-to-expected ratio (observed readmission/average adjusted probability).
R – Reported Rate
Designation NA: Plan had less than 30 members in the denominator

AvDC Performance Improvement Projects

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

MCO Name: Amerivantage Dual Coordination (AvDC)

PIP Topic 1: 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	PM	PM		
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	PM	PM		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 1 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**	**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	PM		
2c. Objectives align aim and goals with interventions	N/A	PM	M		
Element 2 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 2 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 2 Weighted Score	**N/A**	**2.5**	**2.5**	**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	PM		
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	PM	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	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	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 3 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**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	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	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	PM	PM		
Element 6 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 6 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**	**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	PM	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	PM	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	PM	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	PM	M		
Element 7 Overall Review Determination	**N/A**	**PM**	**M**		
Element 7 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**10.0**	**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/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**	**47.5**	**57.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**59.4%**	**71.9%**	**0.0%**	**0.0%**

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

IPRO Reviews: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO was partially compliant regarding 1a supported with MCO data, a concern was identified, 1a, Attestation signed and Project Identifies completed. On page 3, the attestations are signed however are dated 12/15/2021 as in the previous submission. The MCO should ensure the FIDE SNP MCO name is correct, Amerivantage FIDE SNP New Jersey, and a review of the PIP is completed for signatures and accurate dates prior to submission.

Element 2 Overall Review Determination was partially compliant regarding the Aim 2b, Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark. The

MCO has updated the Aim to align with objectives however, the goals set for Indicator #2 and Indicator #3 appear to be measure the same/similar indicator (Telehealth encounters). Both of which monitor the member/provider use of Telehealth. On page 16, the MCO provides a screen of Telehealth utilization for 2019 and 2021, noting the Baseline has updated to reflect no Telehealth use in 2019 and increase use in 2021. The MCO might consider replacing Indicator #2 with PCP visit utilization for a well-rounded view of where Telehealth might be a valuable additive to the provider practices during MY 2 of the PIP. Additionally, the MCO might review Short Term and Long Terms goals for Indicators #2 and #3 considering MY 1 result for Indicators #2 and #3. The MCO should review Aim Statement, Objectives, and Goals to consistently align the PIP sections accordingly.

Element 3 Overall Review Determination was partially Complaint regarding Methodology, 3a. Performance Indicators (PIs) are clearly defined and measurable (specifying numerator and denominator criteria). As noted in Element 2, PIs #2 and #3 appear to measure the same or similar encounter data (member/provider) for Telehealth occurrence. The MCO might consider review of the Performance Indicators to align with the Aim, Objectives, and Goals of the PIP. On page 7, the baseline and goals have been updated for this submission, however the data regarding goals remains unclear how the Short- and Long-Term Goals of 110% and 120% were decided without explanation. The MCO should improve descriptions and provide clarification regarding the process for the determination of the Goal Rates.

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

Element 5 Overall Review Determination was partially compliant regarding Robust Interventions 5d, a concern was identified with interventions and associated aspects, including how Intervention Tracking Measures (ITMs) were described in Table 1b. On page 17, ITM 1a, Yr. 1 Q1, Yr. 1 Q2, Yr.1 Q3 calculations exhibit inconsistent decimal rounding writing conventions. The MCO should standardize numerical writing conventions for accuracy and consistency across tables over the life of the PIP. Decimal placement might exhibit one or two places consistently promoting confidence in the accuracy of the data and for effective evaluation of the PIP.

Element 6 Overall Review Determination was partially compliant regarding the Results Table, 6a. The Results Table has been updated to reflect available Baseline data; however, Indicators #1and #3 for the Baseline does not provide numerator/denominator data for the Rates documented (79.7%) and (58%), Yr. 1, Indicator #1 numerator/denominator (7/9=22.22%) which is inaccurate as well as Yr. 1, Indicator #3 contains percentages in the numerator/denominator (17%/23%=6%). The MCO should review all calculations, make the appropriate corrections and update for the next submission.

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 addressed.

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 57.5 points, which results in a rating of 71.9% (which is below 85% [≥ 85% being the threshold for meeting compliance]). Concerns were identified with aspects of the Aim, Methodology, Interventions and Results Table. The MCO should review each concern as noted above, address the above concerns with clarifications or adjustments for a well-developed PIP that is able to demonstrate the intended impact on performance outcomes. Additionally, the MCO should review the MCO name to ensure the PIP exhibits the correct MCO name according to the contract for each submission.

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

MCO Name: Amerivantage Dual Coordination (AvDC)

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

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	PM		
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**	**PM**		
Element 1 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**	**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	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	N/A	N/A	M		

technique specifies estimated/true frequency, margin of error, and confidence interval.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	PM	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	**PM**	PM		
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**	**PM**		
Element 4 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 4 Weighted Score	**N/A**	**7.5**	**7.5**	**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	PM	PM		
Element 6 Overall Review Determination	**N/A**	PM	**PM**		
Element 6 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**	**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	PM	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	PM	M		
Element 7 Overall Review Determination	**N/A**	PM	**PM**		
Element 7 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**10.0**	**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**	**N**	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**40.0**	**50.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**50.0%**	**62.5%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: September 22, 2022
Reporting Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was partially compliant regarding the Attestation signed and Project Identifiers Completed 1a, a concern was identified with the Change Table on page 2, the Change Table was not updated to reflect changes noted in the Year 2 update. For example, on pages 10-11, the Barrier Analysis Table 1a, Barrier #3, has been updated to ITM 3a, ITM 3b, and ITM 3c. ITM 2b does not include a corresponding numerator /denominator. The MCO should review all previous and subsequent updates to ensure that all changes to the PIP, additions, terminations, adjustments, and edits are updated on the Change Table. The Change Table is an important mode of tracking changes and progression of the PIP over time to ensure a comprehensive and accurate evaluation year over year. Additionally, on page 3, Attestation does not have the correct date for this submission. The date continues to read 9/25/2020 from the proposal submission. This issue was identified at the last submission as should corrected for the next August 2022

submission. The MCO should review all sections of the PIP prior to each submission thereby ensuring the accuracy of the PIP for each submission.
Element 2 Overall Review Determination was that the MCO is compliant.
Element 3 Overall Review Determination was that the MCO is compliant.
Element 4 Overall Review Determination was partially compliant in regard to Barrier Analysis Table 1a, a concern continues regarding (Barrier Analysis, Interventions and Monitoring), Barrier #2, ITM 2a numerator /denominator does not correspond with Table 1b 2a ITM; also 2b, is noted to be a new barrier intervention/ITM, however there is no corresponding numerator/ denominator associated and there is no corresponding ITM on Table 1b for tacking. The MCO should review and adjust to align the Barrier Analysis Table 1a and Quarterly Reporting Table 1b accordingly.
Element 5 Overall Review Determination was partially compliant regarding Robust Interventions, a concern was identified with aspects of 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 12, Table 1b exhibits multiple concerns regarding decimal rounding writing conventions. For example, ITM 1a, Y1 Q3, 7/1151=06% however the calculation equals 0.61%; ITM #3 Y1 Q2 202/364=55% however in Y1 Q3 412/564=73.04%. There are multiple examples throughout Table 1b. The MCO should review all calculations for accuracy and apply a consistent decimal rounding approach to provide accuracy of the data over the life of the PIP.
Element 6 Overall Review Determination was partially compliant regarding the Result Table #6, a concern was identified regarding decimal rounding practices and calculation accuracy. In Year 2 of the PIP, consistent decimal rounding practices and numerical information should exhibit standard practice. The MCO should consider adding numeric writing conventions to the Methodology section of the PIP to standardize numerical calculations and rounding practices.
Element 7 Overall Review Determination was partially compliant regarding 7b data presented adhere to statistical techniques outlined int he MCO's data analysis plan. In Element # 5 above the MCO exhibits continued difficulty with statistical writing conventions and consistency across all sections of the PIP. Table 1b and Table 2 both exhibit the lack of a consistent decimal rounding practice. Consistent and accurate data calculations is essential in providing a consistent comprehensive evaluation of interventions/ITM progress and effective over the life of the PIP. The MCO should take a complete review of all numerical information and update accordingly.
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 have not been addressed.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 50.0 points, which results in a rating of 62.5% (which is at below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has appropriately updated the project adding additional interventions/ITMs however, continues to exhibit the lack of consistent numerical data to rely on. The MCO has noted the A1C home test kits are exhibiting positive results as well as noting limitations office staffing and wrong phone numbers for outreaching members. The MCO should update the alignment of barriers, interventions, and ITMs clearly and consistently across all tables throughout the life of the PIP. 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. Additionally, the MCO should review the Plan name to ensure the PIP exhibits the correct Plan name according to the contract for each submission (Amerigroup versus Amerivantage- FIDE SNP).

Horizon NJ TotalCare (HNJTC)

HNJTC: 2022 Annual Assessment of FIDE SNP/MLTSS Operation

Review Category	Total Elements	Met Prior Audit	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	19	16	12	17	2	0	89%	2	1	0
Quality Assessment and Performance Improvement	9	9	9	9	0	0	100%	0	0	0
Quality Management	14	14	9	14	0	0	100%	0	0	0
Committee Structure	9	8	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	43	43	10	43	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	11	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	10	10	4	10	0	0	100%	0	0	0
Care Management and Continuity of Care[4]	13	9	6	11	0	2	100%	0	0	0
Credentialing and Recredentialing	10	10	2	10	0	0	100%	0	0	0
Utilization Management	44	39	15	42	0	2	100%	0	2	0
Administration and Operations	20	19	3	20	0	0	100%	0	0	0
Management Information Systems	22	19	0	22	0	0	100%	0	0	0
TOTAL	**224**	**207**	**77**	**218**	**2**	**4**	**99%**	**2**	**3**	**0**

[1] The MCO was subject to a full review in the previous review period.

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

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

[4] Four (4) additional CM elements were added in 2022 for FIDE SNP only.

HNJTC Performance Measure Validation – FIDE SNP Measures

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

Findings

- HNJTC reported the required measures for HEDIS MY 2021.

HNJTC MY 2021 FIDE SNP Performance Measures	Rate	Status
Colorectal Cancer Screening (COL) - Hybrid Measure	51.34%	R
Care for Older Adults (COA) - Hybrid Measure		
Advance Care Planning	78.72%	R
Medication Review	84.46%	R
Functional Status Assessment	80.41%	R
Pain Screening	92.57%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	30.65%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	72.58%	R
Bronchodilator	91.61%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	68.86%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	25.81%	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	72.66%	R
Effective Continuation Phase Treatment	63.31%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-Up	47.22%	R
7-Day Follow-Up	29.37%	R
Transitions of Care (TRC) - Hybrid Measure		
Notification of Inpatient Admission	7.06%	R
Medication Reconciliation Post-Discharge	68.61%	R
Patient Engagement After Inpatient Discharge	88.08%	R
Receipt of Discharge Information	9.00%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [1]		
Falls + Tricyclic Antidepressants or Antipsychotics	41.44%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	49.49%	R
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	15.79%	R
Total	40.41%	R
Use of High-Risk Medications in the Elderly (DAE)[1]	24.76%	R
Plan All-Cause Readmissions (PCR) [1,2,3]		
18-64 year olds, Observed-to-expected Ratio	1.4801	R
65+ year olds, Observed-to-expected Ratio	1.3353	R

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

[2]PCR is a risk adjusted measure.

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

R – Reported Rate

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

HNJTC Performance Improvement Projects

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

MCO Name: Horizon NJ TotalCare (HNJTC)

PIP Topic 1: Increasing PCP Access and Availability for Members with high ED utilization -Horizon NJ TotalCare (FIDE SNP) 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	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	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	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	PM		
Element 5 Overall Review Determination	**N/A**	M	PM		
Element 5 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**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 (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**	**72.5**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 2022
Reporting Period: Year 2

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). On page 21, Table 1b, Y2 Q1 exhibits inconsistent rounding writing conventions. Additionally, on pages 11 Indicator 4 CompleteCare Health Network, and page 12 Cooper Physician Offices PA and Indicator 1 for G and S Medical Associates. In Section 6, Results, Table 2 there is a calculation error page 27, Cooper Family Medline PA, Indicator 2. The MCO should review for consistent rounding conventions and ensure all calculations are reviewed prior to submission.
Element 6 Overall Review Determination is that the MCO is compliant.
Element 7 Overall Review Determination is that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that Healthcare disparities evaluated and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has progressed and made despite the COVID-19 Pandemic and disruptions in services. The MCO has identified that engagement with members and providers are key factors in making progress toward the goals of the PIP. The MCO continues to collaborate with Cooper Family Medicine and Cooper Physician Offices PA regarding the restructuring of several of their PCPs as Cooper Physician Offices of PA no longer exists. The MCO also noted the are opportunities to improve regarding members that are not utilizing their PCPs. The MCO's engagement with the PCPs is integral in providing insight as inform next for increase PCP utilization. The MCO might consider reviewing the top 5-10 diagnoses that members that utilize the Emergency Room as a discussion point with the PCPs. The MCO continues to progress in a well-developed PIP, making strides and adjustments as identified to achieve the goals of this PIP.

HNJTC PIP Topic 2: Horizon NJ TotalCare (FIDE SNP) Diabetes Management

MCO Name: Horizon NJ TotalCare (HNJTC)

PIP Topic 2: Horizon NJ TotalCare (FIDE SNP) Diabetes Management

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	N/A	M	M		

technique specifies estimated/true frequency, margin of error, and confidence interval.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	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	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	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**	**72.5**	**80.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**100.0%**	**0.0%**	**0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: September 22, 2022
Report Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is complaint.
Element 2 Overall Review Determination was that the MCO is complaint.
Element 3 Overall Review Determination was that the MCO is complaint.
Element 4 Overall Review Determination was that the MCO is complaint.
Element 5 Overall Review Determination was that the MCO is compliant.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 2 phase.

Element 9 Overall Review Determination was that Health disparities were not identified, evaluated, and addressed.

Overall, the MCO is compliant with this PIP for the reporting requirement; 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 notes successes for the members as OTC catalog benefits and have an opportunity to order a BP cuff for self-monitoring, eligible for Healthy Food Benefits which receive a quarterly $375.00 to purchase healthy foods. However, a limitation noted was that as restrictions are lifting, members are eating out more which may not include healthy foods. On page 26, Y2 Q1 identified a small calculation error that the MCO should review and update. The MCO should continue to review and update as appropriate ensuring any changes are documented on the Change Table on page 3.

UnitedHealthcare Dual Complete One (UHCDCO)

UHCDCO: 2022 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Met Prior Audit	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	19	14	12	15	4	0	79%	3	0	1
Quality Assessment and Performance Improvement	9	9	9	9	0	0	100%	0	0	0
Quality Management	14	14	9	13	1	0	93%	0	0	1
Committee Structure	9	8	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	43	43	10	43	0	0	100%	0	0	0
Provider Training and Performance	11	11	5	11	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	10	9	5	10	0	0	100%	0	1	0
Care Management and Continuity of Care	13	8	6	11	0	2	100%	0	1	0
Credentialing and Recredentialing	10	9	3	9	1	0	90%	1	0	0
Utilization Management	44	39	14	41	0	3	100%	0	2	0
Administration and Operations	20	18	4	20	0	0	100%	0	1	0
Management Information Systems	22	19	0	22	0	0	100%	0	0	0
TOTAL	**224**	**204**	**80**	**213**	**6**	**5**	**97%**	**4**	**5**	**2**

[1] The MCO was subject to a full review in the previous review period.

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

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

[4] Four (4) additional CM elements were added in 2022 for FIDE SNP only.

UHCDCO Performance Measure Validation – FIDE SNP Measures

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

Findings

- UHCDCO reported the required measures for HEDIS MY 2021.

UHCDCO MY 2021 FIDE SNP Performance Measures	Rate	Status
Colorectal Cancer Screening (COL) - Hybrid Measure	75.43%	R
Care for Older Adults (COA) - Hybrid Measure		
Advance Care Planning	62.04%	R
Medication Review	89.54%	R
Functional Status Assessment	73.71%	R
Pain Screening	91.00%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	37.92%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	68.35%	R
Bronchodilator	88.01%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	76.16%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	86.54%	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	55.56%	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	76.77%	R
Effective Continuation Phase Treatment	59.71%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-Up	46.93%	R
7-Day Follow-Up	25.24%	R
Transitions of Care (TRC) - Hybrid Measure		
Notification of Inpatient Admission	3.65%	R
Medication Reconciliation Post-Discharge	47.45%	R
Patient Engagement After Inpatient Discharge	77.13%	R
Receipt of Discharge Information	3.41%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [1]		
Falls + Tricyclic Antidepressants or Antipsychotics	40.82%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	56.17%	R
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	17.88%	R
Total	45.38%	R
Use of High-Risk Medications in the Elderly (DAE)[1]	28.37%	R
Plan All-Cause Readmissions (PCR) [1,2,3]		
18-64 year olds, Observed-to-expected Ratio	1.2655	R
65+ year olds, Observed-to-expected Ratio	1.2932	R

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

[2]PCR is a risk adjusted measure.

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

R – Reported Rate

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

UHCDCO Performance Improvement Projects

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

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

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	PM	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	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	PM		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 3 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**	**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	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	PM		
Element 5 Overall Review Determination	**N/A**	**M**	PM		
Element 5 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**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 (**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**	**65.0**	**65.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**81.3%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 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 partially compliant regarding Methodology, 3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. The MCO has discovered initial emergency room visit data was calculated incorrectly by Line of Business, (Medicaid vs. DSNP), which was reported to the Quality Team incorrectly. This

miscalculation has been corrected and updated to reflect the correct 2019 baseline data as well as the goals based on the corrected data. In the first year of the PIP, MY 2021, the MCO identified a set of frequent diagnoses (seven) that indicated potentially avoidable ED visits based on the baseline claims data. Upon review, the MCO added 8 more diagnoses that could potentially be avoidable ED visits by claims review. However, in MY 1, pages 42-47, for ITMs 1a-3c, a concern regarding low volumes is noted which continues in MY 2. Low volumes could result in a potential viability issue and questionable results. The MCO should review the potential of additional avoidable emergency room occurrences and/or the potential to expand the eligible population to increase data resulting in viable outcomes. For example, Table 1b, pages 42-47, ITMs 1a- 3c exhibit multiple NAs or O.O% percentage rates. Additionally, footnote number #3 states, "The denominator includes members who identified in Q2, Q3, Q4 2022." for ITM 5a-c, however this footnote should relate to MY 2021. The MCO should review the concerns noted above, adjusting as appropriate to ensure data validity and accuracy for a well-developed 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). The MCO has identified a calculation error in the data as noted above, updated with the corrected data, and implemented two (2) new interventions. Additionally, the MCO acknowledges continued low volume and small DSNP panel which lead to limited data in support the Aim, Objective and obtain the Goals of the PIP. The MCO continues to meet with providers, collaborating regarding results over the MY 1 adjusting PIP interventions MY 2 in response to the data.
Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.
Element 9 Overall Review Determination was N/A. Healthcare disparities were not identified, evaluated, and addressed at the proposal phase.

Overall, the MCO is partially compliant with this PIP for the reporting requirement; out of a maximum possible weighted score of 80.0 points, the MCO scored 65.0 points, which results in a rating of 81.3% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant adjustments to the PIP, although the MCO continues to face challenges with outreach to members, low volume data, providers continue to struggle with patient flow. The MCO continues to collaborate with providers, although notes that 1 provider has been acquired by Village Medical, another is in the process of being acquired by RWJ/Barnabas Health and another has expanded the Call Center to accommodate the increased volume of incoming and outgoing calls. The MCO should review and address the concerns noted above with clarifications and/or adjustments for a well-developed PIP that demonstrates the projected impact on the performance outcomes.

UHCDCO PIP Topic 2: Promoting Adherence to Renin Angiotensin (RAS) Antagonists Hypertensive Medications

MCO Name: UnitedHealthcare Dual Complete One (UHCDCO)

PIP Topic 2: Promoting Adherence to Renin Angiotensin (RAS) Antagonists Hypertensive Medications

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	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	PM	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	PM	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	**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	PM	M		
5c. New or enhanced, starting after baseline year	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	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	PM	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	PM	M		
Element 7 Overall Review Determination	N/A	PM	**M**		
Element 7 Overall Score	N/A	**50**	**100**	**0**	**0**
Element 7 Weighted Score	N/A	**10.0**	**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/A**	**N**	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**45.0**	**80.0**	**0.0**	**0.0**
Overall Rating	**0%**	**56.3%**	**100.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: September 19, 2022
Reporting Period: Year 2

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 complaint.

Element 5 Overall Review Determination was that the MCO is compliant

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

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

Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 2 phase.

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

Overall, the MCO is compliant with this PIP for Year 2 reporting requirement; 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 had made a comprehensive review and extensive update of each section of the PIP reflecting appropriate information and data within the PIP Template and requirements. The MCO acknowledges the Performance Indicators exhibit progress toward the long term goals although still have more to go. Additionally, the MCO also notes some limitations such as members understanding how to obtain 90-day supply of medication to prevent running out causing a gap in the medication regime, not all members will qualify for a 90-day supply due to the need of frequent medication changes and incorrect phone numbers continues to delay outreach attempts. The MCO should review for all information no longer relevant should be termination with an explanation, documenting on the Change Table.

WellCare Dual Liberty (WCDL)

WCDL: 2022 Annual Assessment of FIDE SNP/MLTSS Operations

Review Category	Total Elements	Met Prior Audit	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	19	16	12	16	3	0	84%	2	1	1
Quality Assessment and Performance Improvement	9	9	9	9	0	0	100%	0	0	0
Quality Management	14	14	9	14	0	0	100%	0	0	0
Committee Structure	9	8	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	43	43	10	42	0	1	100%	0	0	0
Provider Training and Performance	11	10	6	11	0	0	100%	0	1	0
Enrollee Rights and Responsibilities	10	10	4	10	0	0	100%	0	0	0
Care Management and Continuity of Care	13	9	6	11	0	2	100%	0	0	0
Credentialing and Recredentialing	10	10	2	10	0	0	100%	0	0	0
Utilization Management	44	42	15	41	1	2	98%	0	0	1
Administration and Operations	20	20	3	20	0	0	100%	0	0	0
Management Information Systems	22	22	0	22	0	0	100%	0	0	0
TOTAL	**224**	**213**	**79**	**215**	**4**	**5**	**98%**	**2**	**2**	**2**

[1] The MCO was subject to a full review in the previous review period.

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

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

[4] Four (4) additional CM elements were added in 2022 for FIDE SNP only.

WCDL Performance Measure Validation – FIDE SNP Measures

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

Findings

- WCDL reported the required measures for HEDIS MY 2021.

WCDL MY 2021 FIDE SNP Performance Measures	Rate	Status
Colorectal Cancer Screening (COL) - Hybrid Measure	58.15%	R
Care for Older Adults (COA) - Hybrid Measure		
Advance Care Planning	43.07%	R
Medication Review	93.43%	R
Functional Status Assessment	58.64%	R
Pain Screening	93.92%	R
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	31.43%	R
Pharmacotherapy Management of COPD Exacerbation (PCE)		
Systemic Corticosteroid	65.91%	R
Bronchodilator	90.91%	R
Controlling High Blood Pressure (CBP) - Hybrid Measure	71.29%	R
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	R
Osteoporosis Management in Women Who Had a Fracture (OMW)	NA	R
Antidepressant Medication Management (AMM)		
Effective Acute Phase Treatment	75.38%	R
Effective Continuation Phase Treatment	56.15%	R
Follow-Up After Hospitalization for Mental Illness (FUH)		
30-Day Follow-Up	46.32%	R
7-Day Follow-Up	32.63%	R
Transitions of Care (TRC) - Hybrid Measure		
Notification of Inpatient Admission	12.17%	R
Medication Reconciliation Post-Discharge	45.01%	R
Patient Engagement After Inpatient Discharge	79.56%	R
Receipt of Discharge Information	4.87%	R
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE) [1]		
Falls + Tricyclic Antidepressants or Antipsychotics	45.95%	R
Dementia + Tricyclic Antidepressants or Anticholinergic Agents	55.66%	R
Chronic Renal Failure + Nonaspirin NSAIDs or Cox-2 Selective NSAIDs	21.78%	R
Total	49.42%	R
Use of High-Risk Medications in the Elderly (DAE)[1]	29.08%	R
Plan All-Cause Readmissions (PCR) [1,2,3]		
18-64 year olds, Observed-to-expected Ratio	1.0016	R
65+ year olds, Observed-to-expected Ratio	1.0513	R

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

[2]PCR is a risk adjusted measure.

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

R – Reported Rate

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

WCDL Performance Improvement Projects

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

MCO Name: WellCare Dual Liberty (WCDL)

PIP Topic 1 : FIDE-SNP 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	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	PM	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	M	PM		
Element 5 Overall Review Determination	**N/A**	M	PM		
Element 5 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**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 (**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**	**72.5**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 20, 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 partially compliant regarding Robust Intervention, 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 acknowledges the limited data regarding Table 1b, ITMs and had appropriately footnoted each instance where there was a delay or data update. The MCO has taken steps to remedy by adding two (2) adding interventions in Yr.2 Q2 and Yr.2 Q3. Additionally, the MCO has provided information regarding a deep dive into why members choose the Emergency Room rather than their PCP. On pages 33-34 the MCO describes member responses to why utilization of the Emergency Room in lieu of the PCP office. In part, for those members who have chosen to provide details, 75% of the members went to the Emergency Room for valid reasons which include, falls, pain, and allergic reaction. The remaining 25% stated that the service was better, the MD was not available and/or the MD was not helpful. The MCO implemented additional tracking measures to educate providers regarding Access and Availability Standards quarterly as well as outreaching members who had urgent care visits. Additionally, the providers are being provided a handout to educate members of the importance of PCP visits as well as appropriate use of the Emergency Room for urgent/emergent care. The MCO should continue to review, refine, and track and trend with data for each measurement year identifying limits and accomplishments over the life of the PIP. The MCO should continue to increase data support of the interventions/ITM data for a fully comprehensive, data driven PIP that supports and validates the outcome goals.
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 and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO continues to make updates and adjustments to PIP as appropriate when identified. The MCO should address the above concerns with clarifications or adjustments for a well-developed PIP that ultimately demonstrates the intended impact on performance outcomes.

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

MCO Name: WellCare Dual Liberty (WCDL)

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

technique specifies estimated/true frequency, margin of error, and confidence interval.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	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	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	PM		
Element 5 Overall Review Determination	**N/A**	**M**	**PM**		
Element 5 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**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 (**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**	**72.5**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: September 22, 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 complaint.
Element 4 Overall Review Determination was that the MCO is compliant.

Element 5 Overall Review Determination was that the MCO is compliant 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 17, Y1 Q4, ITM #1b 16/270=5.92%, however the rounding of decimals pattern is to round up which would yield 59.3%. In Y1 Q4, #2a, and Y1 Q3 #2b, calculations exhibit a similar pattern. On page 22, Table 2 Results exhibits similar rounding patterns. The MCO should review decimal rounding conventions to ensure accuracy and consistency of the data over the life of the PIP using one mode of decimal rounding.

Element 6 Overall Review Determination was that the MCO is compliant.
Element 7 Overall Review Determination was that the MCO is compliant.
Element 8 Overall Review Determination was N/A. Sustainability in not evaluated at the Year 2 phase.
Element 9 Overall Review Determination was that Healthcare disparities were not identified, evaluated, and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is at least or above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should review decimal placement and rounding standard writing conventions, maintain one style throughout the PIP to ensure consistent and accurate data capture year over year. The MCO should review and update all concerns noted above documenting changes on the Change Table as appropriate.