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

CORE MEDICAID and MLTSS QUALITY TECHNICAL REPORT

January 2020–December 2020

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realized.

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EXECUTIVE SUMMARY

Background

The New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits to children and adults with low-to-moderate incomes. DMAHS purchases medical care coverage through contracts with managed care organizations (MCOs). The MCOs receive a fixed, prospective, monthly payment for each enrollee of the NJ FamilyCare Managed Care Program. The NJ FamilyCare Managed Care Contract specifies the compliance requirements that must be maintained for finances, service delivery, quality-of-care terms and conditions.

The MCOs Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and WellCare Health Plans of New Jersey, Inc. (WCHP) participated in the NJ FamilyCare Managed Care Program in 2020. As per DMAHS, enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long Term Services and Supports (MLTSS) was 1,837,833 as of 12/31/2020.

External quality review (EQR) activities conducted during January 2020–December 2020 included annual assessment of MCO operations, performance measure (PM) validation, performance improvement projects (PIPs), focused studies, DMAHS encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, Core Medicaid care management (CM) audits, and MLTSS CM audits.

State Initiatives

The following information for the state initiatives is provided by DMAHS and included verbatim herein.

Autism Spectrum Disorder (ASD)

Effective January 1, 2020 NJ FamilyCare added a wide array of new and existing services to treat children with Autism Spectrum Disorder (ASD). Services that were provided by the managed care plans for diagnoses outside of ASD included physical, occupational, and speech therapy; sensory integration; and communication assistive devices and services. Now, the managed care plans must include these services for children with autism. Other behavioral health services were provided by the Children's System of Care (CSOC) within the Department of Children and Families (DCF). These services included skill acquisition and capacity building services which would continue to be provided by CSOC through fee-for-service. Newly enrolled children with moderate to severe autism are eligible to apply for these and other CSOC services intended to support families and ameliorate their condition. As a result of this split responsibility for services, the managed care plans work with CSOC's care management organizations to provide these services in a coordinated and cooperative fashion. As a result, there is no wrong door as families are referred to any service designed to meet their child's identified needs. To further improve the benefit, new services were added or enhanced. Applied Behavior Analysis (ABA), was initially offered under the 1115 Comprehensive waiver as a pilot but had significant limitations. Only a small number of children were able to access this benefit. The new ABA benefit has expanded access to all children diagnosed with ASD under the age of 21 and removed all barriers to service. Since New Jersey has one of the highest per capita rates of autism in the country, managed care has been tasked with expanding the existing provider network required to meet anticipated demands for this service. In addition, NJ FamilyCare became the first Medicaid program to offer Developmental Individual-based Relationship (DIR) Model and other developmental treatment services for children with ASD based on promising new research that has shown the potential benefit of these services. All these services are now part of an Early Periodic Screening Diagnostic and Treatment (EPSDT) comprehensive benefit required by the Centers of Medicare & Medicaid Services (CMS) to expand options and provide family choice.

Behavioral Health/Substance Use Disorder Services

As of July 1, 2019, NJ FamilyCare began providing coverage of peers for substance use disorder (SUD) treatment provided in an independent clinic that is licensed to provide substance use services. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Certified Peer Recovery Specialist (CPRS) workers who have been

successful in the recovery process and can help others with SUD through shared understanding, respect, and mutual empowerment. Peers have been shown to help people become and stay engaged in the recovery process, thereby reducing the likelihood of a relapse. CPRS services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Effective July 1, 2020, NJ FamilyCare began coverage of Substance Use Disorder (SUD) care management services. Care management is a behavioral health service intended to support NJ FamilyCare beneficiaries who have SUD with complex physical or psychosocial needs. Care managers assist beneficiaries as they transition throughout the SUD continuum of care by matching their perceived needs with available resources and then assisting them to access care. Care managers work with beneficiaries to implement strategies that prevent opioid substance misuse by guiding the treatment team to process identified tasks. To accomplish this, care managers build collaborative relationships with non-opioid treatment providers to address identified needs.

Electronic Visit Verification

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

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

The State Medicaid Agency (SMA) has enhanced ability to prevent fraud, waste, and abuse through increased visibility into its Home and Community Based Services programs.

The EVV solution is reliable, accessible, and minimally burdensome on providers, beneficiaries, and their caregivers.

Appropriate safeguards of electronic protected health information and personally identifiable information are implemented and maintained.

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

Maternal/Child Health Initiatives

Aligning with the NurtureNJ campaign of First Lady Tammy Murphy, NJ enacted legislation in recent years to improve the state's maternal and infant health outcomes—with a special focus on racial disparities. Many of these laws expanded services under NJ FamilyCare or added stipulations on reimbursement of maternity-related services. Our 2020 Maternal/Child Health Initiatives were focused on implementation of those laws, including:

Centering Pregnancy is now a covered NJ FamilyCare benefit (see NJ P.L.2019, c.237). Centering Pregnancy is an evidence-based model of group prenatal care accredited by Centering Healthcare Institute. It provides the same standard of care as traditional models of prenatal care delivery, while also providing peer support and greater access to the clinician. This initiative was effective December 2019.

Doula care is now a covered NJ FamilyCare benefit (see NJ P.L.2019, c.85). Doulas are a new NJ FamilyCare provider type. They provide non-clinical emotional, physical, and informational support throughout the perinatal period. Doulas do not

replace perinatal care by an obstetric clinician, but doula care is an evidence-based intervention that can improve birth-related outcomes and the birth experience. This initiative was effective January 2021.

Reimbursement of prenatal care for the pregnant member covered by NJ FamilyCare is contingent on the completion of a Perinatal Risk Assessment PRA Plus form (see N.J. P.L.2019, c.88). A provider's completion of the PRA Plus First Visit, Follow Up, and Third Trimester forms are newly-reimbursable services. The PRA Plus form is a uniform screening tool that aids the provider in identifying the member's medical and social needs, supports our Medicaid MCOs in pregnancy risk stratification, and facilitates referrals for some Community Based resources available through the state's Central Intake system. In 2020, the PRA Plus form was updated to include COVID-19-related questions. This initiative was effective January 2021.

NJ FamilyCare ended reimbursement of labor and delivery-related professional and facilities claims associated with Early Elective Deliveries (see N.J. P.L.2019, c.87). Early elective deliveries are medically-unnecessary C-section and inductions prior to 39 weeks. This initiative was effective January 2021.

New Jersey Delivery System Reform Incentive Payment (NJ DSRIP)

The New Jersey Delivery System Reform Incentive Payment (NJ DSRIP) program was one component of the New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP was a demonstration program designed to result in better care for individuals, better health for the population, and lower costs by transitioning hospital funding to a model where payment was contingent on achieving health improvement goals. Hospitals were qualified to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system. The program was initially a five-year program but was approved for extension by CMS in July 2017. The NJ DSRIP program ended on June 30, 2020.

Quality Improvement Program – New Jersey (QIP-NJ)

To support continued population health improvement across New Jersey following the conclusion of the Delivery System Reform Incentive Payment (DSRIP) program on June 30, 2020, the State had planned to implement a program promoting the health of NJ's Medicaid population through performance-based payments focused specifically on improvements for the maternal health population and the behavioral health populations. QIP-NJ was proposed to begin on July 1, 2020, pending CMS approval. However, New Jersey, like many other states across the country, has been managing the critical response to the COVID-19 public health crisis. The impact this virus has had on the health system has been deep and far ranging, and as such, the State delayed the implementation of QIP-NJ by one year to July 1, 2021 and extended the end date of the program to June 30, 2024. The program is currently pending CMS approval.

In the interim year, New Jersey has been approved by CMS to administer a time-limited directed payment to support the financial stability of acute care hospitals. The interim time-limited directed payment, known as the QIP "Bridge" payment, was submitted via a Section 438.6(c) Preprint by DOH and DHS earlier this summer. The payment received CMS approval on September 17, 2020. In compliance with 438.6(c)(2)(i)(A), New Jersey will require each of the state's Medicaid Managed Care Organizations (MMCOs) to issue a per diem add-on payment to hospital inpatient claims across several proposed classes of providers. The State has proposed two semi-annual payments (P1: 03/2021, P2: 9/2021) made by the state's MCOs to each hospital. MCOs would receive 50% of the total amount available for distribution for each pool at the close of each utilization period. Funds originally programmed for QIP-NJ for July 2020-June 2021 (SFY2021) will be used as the source of funding for this investment.

Health Information Technology and the Medicaid Enterprise System

DMAHS continues to recognize the critical role of health information technology (HIT) as a transformation enabler.

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid including the establishment of an overall Medicaid Enterprise System (MES) strategy encompassing IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E) and the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the

program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Management Information System

The MMIS is an important component of program operations that is vital to advancing the goals of DMAHS and other agencies that comprise the Medicaid enterprise to provide services that are cost-effective and result in high quality outcomes.

With guidance from CMS, DMAHS is currently modernizing the MMIS. The modernization strategy includes leveraging the current MMIS as the modernization platform by deploying enhancements to its existing functions and capabilities. In addition, the strategy is also to identify MMIS modules and processes that will be modernized, such as system integrator, drug rebate and provider management. The goal of the modernization project is to provide DMAHS with the system infrastructure, technical capabilities, and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation. The new system, referred to as the MMIS Modernization, will help ensure that members receive quality, coordinated, and person-centered health services, that programs are effectively administered with the help of decision support tools, and that fraud, waste, and abuse are prevented, detected, and addressed. The MMIS-M will enable NJ to achieve program goals that are critically intertwined with health information technology and electronic exchange of data to improve health outcomes and control program costs.

NJ FamilyCare Integrated Eligibility System

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

The NJ FamilyCare IES continues to utilize modular services that enhances the client and worker experience. The MAGI in the Cloud software service, designed and maintained by CMS and operated through New England States Consortium Systems Organization (NESCSO) is used to automate MAGI eligibility determination. This service allows all NJ MAGI eligibility and program determinations to be done consistently using one set of rules. NJ FamilyCare is configured to interface with the Federal Data Services Hub (FDSH). The FDSH Account Transfer (AT) functionality was set-up to electronically receive beneficiary accounts determined eligible by the Federally Facilitated Marketplace (FFM) using New Jersey eligibility rules. In addition, the web service known as the Medicaid Eligibility Check was established to allow the FDSH to check if applicants are already NJ FamilyCare beneficiaries. The MEC has avoided thousands of duplicate applications because the FDSH can inform the applicant in real-time that they already have NJ FamilyCare coverage. Through the FDSH, the Social Security Administration (SSA) federal data hub verification was implemented. NJ FamilyCare uses the SSA verification to verify name, date of birth, social security number, citizenship and death status for each household member as well as SS Title II income for all applications received daily.

NJ FamilyCare's address verification is another modular service that confirms addresses entered in applications are accurate US Postal Service deliverable addresses. This eliminates waste and access to coverage issues created by undeliverable mail. An asset verification system (AVS) was implemented for the Aged, Blind and Disabled (ABD) program that returns client's end-of-month bank account balances for the five-year asset look back. The system provides access to all national, regional, and local banks.

The NJHelps.org Screening Tool launched in 2017 via a joint initiative with the Division of Family Development. NJHelps was developed as a shared online screening tool allowing New Jersey clients a single point of entry to screen eligibility for health coverage (Medicaid), food (Supplemental Nutrition Assistance Program or SNAP) and cash assistance (Temporary Assistance for Needy Families or TANF and General assistance or GA).

In 2018, NJHelps was expanded to include a client portal. NJHelps client portal provides registered NJ FamilyCare applicants online access to application status, ability to upload required documentation and secure electronic notices (e-notices). E-notices are being implemented in phases as notices are added to NJ FamilyCare. E-notices will start with application confirmation and then add missing information, and eligibility determination notices. Additional FDSH enhancements, Verify Lawful Presence (VLP) to validate immigration status and SSA Title II to verify Social Security Income benefits were also developed and deployed in 2018.

Also in 2019, the NJ FamilyCare IES deployed Presumptive Eligibility and is currently implementing electronic Renewals and Redeterminations. These functionalities will only continue to improve eligibility determination processing time in order to provide for the healthcare needs of the most vulnerable beneficiaries in the STATE.

In the coming year, New Jersey will transition from the Federal Facilitated Marketplace to a State Based Exchange, the NJ FamilyCare IES is currently being prepared and positioned to accommodate the expected increase in application processing and determination to make certain that health care benefits available to those in need.

HITECH and the Promoting Interoperability Program

New Jersey continues to successfully govern and maintain adequate oversight of the Medicaid Promoting Interoperability Program.

The State Medicaid continues to partner with its Regional Extension Center – New Jersey Innovation Institute (NJII) and leverage their expertise to support the ongoing efforts for provider education, outreach and technical assistance in EHR utilization and Meaningful Use attestation under the Medicaid Provider Program.

In 2019, in support of the SUD 1115 demonstration waiver, the HITECH program also operationalized the state-funded Substance Use Disorder Promoting Interoperability Program (SUD PIP) to enable SUD providers to utilize the EHR systems to improve data access and increase interoperability between physical and behavioral health providers. An SUD HIT workgroup was formed to administer and oversee this program including tracking of incentive payments to SUD providers and meaningful utilization of appropriate electronic health record systems. New Jersey being one of the only states that successfully launched and operationalized the SUD Promoting Interoperability program, CMS invited New Jersey to present in national conferences and webinars to share these efforts and strategies with other interested states.

Additionally, New Jersey received approval of enhanced federal funding and has begun pursuing the initiatives to improve connections to the state registries and increase consumer data access for the Federal Fiscal Year 2020-2021.

Medicaid Innovation Accelerator Program (IAP)

CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting the State's efforts to accelerate new payment and service delivery reforms. The main goal of the initiative is to enhance CMS's wide ranging efforts to improve care by supporting system-wide payment and delivery system reform innovation. CMS is using the IAP to work closely with states, consumers, and

health providers on critical issues through technical assistance (TA), tool development, and cross-state and national learning opportunities.

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

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

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

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

A Scope of Work for a VBP initiative was created by the EQRO during 2019 which incorporated MLTSS Performance measures from our HCBS care management audit in addition to PM #13 – MLTSS/HCBS services are delivered in accordance with the Plan of Care, including the type, scope, amount, frequency, and duration. Feedback on the Scope of Work was offered by the coaching team and incorporated into the EQRO'S Scope of Work for this initiative. The TA for the VBP for HCBS ended in July 2019. In 2020, the HCBS VBP initiative continued as an incentive for the MCOs. The top three performing Health Plans were notified of the third year's results of the Managed Long-Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) program, awarding a one-year sliding-scale bonus performance payment based upon data collected by the State's External Quality Review Organization (EQRO).

Community Based Care Management Demonstration

The Community Based Care Management (CBCM) Demonstration project was implemented to provide real time, high touch, in-person care management and intervention for MCO members who are medically and socially complex or high utilizing members. The Demonstration Project was part of the Division's continued efforts to improve quality and health outcomes while managing costs effectively.

Following three years of data collection, the Office of Quality Assurance (OQA) determined that the MCOs' CBCM programs provide a higher level of service within the continuum of care management and should not be a separate program. Members move in to and out of all levels of care management based on their needs. Inclusion of the elements of CBCM allow for a wider range of interventions that are tailored to each member's changing needs; providing the needed level of care management at the right time. The Community Based Care Management demonstration concluded at the end of 2019. Beginning in 2020 Program effectiveness is tracked and trended as part of the contractually established Care Management Monitoring process.

National Core Indicators – Aging and Disabilities (NCI-AD)

The National Core Indicators for Aging and Disabilities© (NCI-AD) are standard measures used across participating states to assess the quality of life and outcomes of seniors and adults with physical disabilities who are accessing publicly-funded services through the Older Americans Act (OAA), Program of All-Inclusive Care for the Elderly (PACE), Medicaid, and/or state-funded programs.

New Jersey has participated in this initiative since NCI-AD's first survey year, 2015-2016, to examine publicly funded long-term services and supports (LTSS) programs regardless of funding source: NJ FamilyCare/Medicaid or PACE.

The MACCs (Medical Assistance Customer Centers), PACE (Program of All-Inclusive Care for the Elderly), NJ Hospital Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey, as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy.

Annual Assessment of MCO Operations

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

2020 Annual Assessment of MCO Operations

In 2020, due to the 2019 novel coronavirus (COVID-19) pandemic, the Annual Assessment audits were conducted virtually via Cisco Webex®. For the review period July 1, 2019–June 30, 2020, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2020 compliance scores from the annual assessment ranged from 93% to 98%. Average compliance for four standards (Quality Assessment and Performance Improvement, Committee Structure, Credentialing and Recredentialing, and Management Information Systems) remained the same from 2019 to 2020. Average compliance for six standards showed increases ranging from 2 to 8 percentage points for Access, Quality Management, Efforts to Reduce Healthcare Disparities, Provider Training and Performance, Utilization Management, and Administration and Operations. In 2020, five standards (Quality Assessment and Performance Improvement, Committee Structure, Provider Training and Performance, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for three standards showed decreases ranging from 2 to 4 percentage points for Programs for the Elderly and Disabled, Satisfaction, and Enrollee Rights and Responsibilities. In 2020, Access had the lowest average compliance score at 77%. Beginning in 2020, 41 elements of the Care Management and Continuity of Care standard were removed from the Annual Assessment Review, and were reviewed and scored independently during the Core Medicaid and MLTSS HCBS Care Management audits. During the offsite audit, IPRO conducted an Information Systems Capabilities Assessment (ISCA) for each MCO the day following the Annual Assessment interviews.

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.

Assessment Methodology

IPRO worked with DMAHS to customize the ISCA worksheet provided in Appendix A 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 Plan 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.

Performance Measures

2020 Core Medicaid Performance Measures

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

Overall, NJ weighted rates remained relatively constant between measurement year (MY) 2018 and MY 2019 (with a < 5 percentage point change year over year) for most measures. Significant improvement (≥ 5 percentage point change) in performance from MY 2018 to MY 2019 were noted for one or more rates of the Adolescent Well-Care Visits (AWC), Prenatal and Postpartum Care (PPC), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Adult BMI Assessment (ABA), Follow Up Care for Children Prescribed ADHD Medication (ADD), Follow-Up After Hospitalization for Mental Illness (FUH), Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Risk of Continued Opioid Use (COU) measures. It should be noted that due to changes to Prenatal and Postpartum Care specifications, year-over-year comparisons are not valid. Significant declines (≥ 5 percentage point change) in performance from MY 2018 to MY 2019 were noted for one or more rates of the Plan All-Cause Readmissions (PCR) measures. Due to significant changes to the Plan All-Cause Readmissions (PCR) measure, caution should be taken when making year-over-year comparisons.

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

Measures reported for MY 2019 by the MCOs can be categorized as follows:

There is one required New Jersey Specific Performance Measure:

1. Preventive Dental Visit

There are three Child Core Set Measures:

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

There are three Adult Core Set Measures:

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

The Preventive Dental Visit is similar to the HEDIS Annual Dental Visit (ADV) measure, but differs in the following ways: this measure has a wider age range for the eligible population than the HEDIS ADV measure (the age range for Preventive Dental is members 2 years old and older as of the anchor date, while the age range for HEDIS ADV is between

2 years and 20 years old), and the numerator for Preventive Dental is preventive evaluations and services only while the HEDIS ADV numerator is any dental service. The Preventive Dental measure is also defined by eligibility categories: Total Medicaid, Medicaid/Medicare Dual-Eligibles, Medicaid-Disabled, and Medicaid-Other Low Income. Every member in the total Medicaid population is assigned to one eligibility category. The sum of the categories equals the total Medicaid results. Finally, the MCOs are required to include all Dual-Eligibles in the NJ Preventive Dental measure, regardless of whether they are included in their Medicaid HEDIS reports.

The Developmental screening is defined by age groups: 1 year old, 2 year old, and 3 year old.

The Diabetes Short-Term Complications Admission Rate is defined admissions by age groups: 18 to 64 years and 65 years and older.

Contraceptive Care measures were added to the report for postpartum women ages 15-20 and ages 21-44 as well as all women ages 15-20 and ages 21-44.

AAP and CAP were removed from the report as the State no longer requires that these measures be broken out by subpopulations.

2020 MLTSS Performance Measure Validation

IPRO worked closely with DMAHS Office of MLTSS Quality Monitoring and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications were updated in 2020 for the July 2020 through June 2021 measurement period for the following PMs:

- #4: Timeliness of Nursing Facility (NF) Level of Care Assessment by MCO
- #18: Critical Incident Reporting
- #20: MLTSS Members Receiving MLTSS Services
- #20a: New MLTSS Members with MLTSS Services Within 120 Days of Enrollment
- #21: MLTSS Members Transitioned from NF to Community
- #23: MLTSS NF to Home and Community Based Services (HCBS) Transitions who Returned to NF within 90 Days
- #33: MLTSS Services Used by MLTSS HCBS Members: PCA Services Only
- #34: MLTSS Services Used by MLTSS HCBS Members: Medical Day Services Only
- #41: MLTSS Services Used by MLTSS HCBS Members: PCA Services and Medical Day Services Only
- #46: MLTSS HCBS Members not Receiving MLTSS HCBS, PCA or Medical Day Services
- #46a: MLTSS HCBS Members with 60 days continuous enrollment in MLTSS HCBS not Receiving MLTSS HCBS, PCA or Medical Day Services
- #47: Post Hospitalization Institutional Care for MLTSS HCBS Members

Additionally, the MCOs also reported the following HEDIS measures for the MLTSS population for measurement period July 2020 to June 2021:

- #26 and #27: Acute Inpatient Utilization by MLTSS HCBS/NF Members (IPU)
- #28 and #29: All-Cause Readmissions of MLTSS HCBS/NF Members to Hospital Within 30 days (PCR)
- #30 and #31: Emergency Department Utilization by MLTSS HCBS/NF Members (AMB)
- #36 and #38: Follow-up After Mental Health Hospitalization for MLTSS HCBS/NF Members (FUH)
- #42 and #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS/NF Members (FUA)
- #44 and #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS/NF Members (FUM)
- #48 and #49: MLTSS HCBS/NF members hospitalized for potentially preventable complications (HPC)
- #50 and #51: Follow-up after emergency department visit for MLTSS HCBS/NF members with high-risk multiple chronic conditions (FMC)
- #52 and #53: Care for older adults for MLTSS HCBS/NF members (COA)

Measures requiring claims have an 8-month lag from the last date of the measurement period to the reporting period, allowing for a 6-month claim lag, 1-month period for report development and 1 month for reporting. The timeframe for validation of claims based measures for the measurement period July 2019 through June 2020 reports ran through February 2021, which is outside the scope of this report.

To ensure consistent and accurate reporting of PMs across MCOs, the EQRO conducted the initial validation of the reported data files and source code for non-HEDIS measures, and monitored the reported rates of all PMs provided by DMAHS on the quarterly basis. Validation of the claims based PMs for the measurement period July 2018 through June 2019 occurred in calendar year 2020.

2020 MLTSS Performance Measure #13

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

In 2020, IPRO completed validation of PM #13 for measurement period from July 2018 to June 2019, including POC abstraction, review of claims data files and source code, validation of blackout period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems.

For the measurement period July 2019 to June 2020, a sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and black-out period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2019 and February 29, 2020. The change of enrollment window from one year to eight months is to address the impact of COVID-19. Validation of PM #13 for this period is ongoing.

2020 VBP MLTSS Service Delivery

VBP MLTSS Service Delivery evaluates delivery of heavily-utilized MLTSS services to members compared with services identified in the plan of care (POC), for HCBS members in a VBP program for NJ Medicaid MCOs. The MLTSS utilized services assessed in this methodology are: Home Delivered Meals, Medical Day Care, Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). In addition to evaluating delivery of services in accordance with the POC, MCOs are evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS; PM #10: Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment; and PM #11: Plans of Care developed using “person-centered principles”.

In 2020, the VBP MLTSS Service Delivery project was based on the measurement period July 1, 2018 and December 31, 2018. A sample of 125 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems. The Primary Source Verification process occurred in the first quarter of 2021, which is outside the scope of this report.

Authorization data were requested in early 2020 to draw samples. Claims data files, source code, POCs, black-out periods files, and supplemental CM notes were submitted by the MCOs. All of the MCOs passed file validation in early 2021, which is outside the scope of this report. The project completion is ongoing in 2021.

Core Medicaid/MLTSS Performance Improvement Projects

For January 2020–December 2020, this QTR includes IPRO's evaluation of the April 2020 PIP updates, August 2020 PIP report submissions, final PIP submissions, and the Fall 2020 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Due to the impact of COVID-19, Element 5 (Robust Interventions) in the August 2020 PIP submissions by the MCOs was excluded from the total score of the PIP.

DMAHS 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 2020, IPRO continues to monitor encounter data submissions and patterns.

Focused Quality Studies

Non-clinical Focused Study Pharmacy Claims vs. Encounter Data

In 2020, the EQRO continued the pharmacy audit focused study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit is to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid and all four FIDE SNP MCOs. The pharmacy encounter data submitted to DMAHS was reconciled to the corresponding source claim data from the originally adjudicated claims and differences were identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018. The EQRO has selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Medicaid and FIDE SNP MCO. The MCOs have provided the adjudicated claim information and the EQRO is in the process of identifying the discrepancies. The EQRO worked closely with the MCOs and EDMU to review the discrepant data elements. The focused study has been completed, and findings will be presented to DMAHS in 2021.

2020 Maternal Mortality Focused Study

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

In 2020, IPRO began data abstraction of medical records and other documentation received from the MCOs and initiated requests for additional medical records from providers who were paid fee-for-service (FFS).

The focused study is currently ongoing, and findings will be presented to DMAHS in 2021.

2020 CAHPS Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health Plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide Children's Health Insurance Program (CHIP) only survey. All of the members surveyed required

continuous enrollment from July 1, 2019 through December 31, 2019, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey.

Care Management Audits

2020 Core Medicaid Care Management Audits

IPRO undertook Core Medicaid Care Management (CM) Audits of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM programs and CM services provided to all MCO members by these MCOs. The populations in the audits included members under the Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). The General Population was not evaluated during the 2020 audit period.

In 2019 and 2020, IPRO, and OQA collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions were limited to exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the 2020 review period will not be compared to the prior year's reported rates because there can be no direct comparison from the 2020 audit tool to the 2019 audit tool.

The MY 2019 rates across all MCOs, populations, and categories ranged from 69% to 100%. Scores for Outreach ranged from 93% to 100% for all MCOs for all populations (DDD and DCP&P). Scores for the Preventive Services Category ranged from 69% to 91% across all MCOs for all populations. Scores for Continuity of Care ranged from 72% to 95% across all MCOs for all populations. Scores for Coordination of Services ranged from 98% to 100% across all MCOs for all populations.

Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD and DCP&P) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 40 scores.

In addition to the Core Medicaid Care Management DDD and DCP&P chart review audit, in 2020 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The Care Management assessment covered the period from January 1, 2019 to December 31, 2019. Due to COVID-19, the interviews with the MCOs were delayed. The interviews were subsequently held with key MCO staff via WebEx in July 2020 to review post-offsite evaluation of documentation and offsite activities. There are 30 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 83% to 90% in 2020.

2020 MLTSS HCBS Care Management Audits

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

audit is from July 1st through June 30th. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2019 through 2/29/2020. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members were included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System and contract references. In 2019 and 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions members represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MLTSS HCBS Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the 2020 review period will not be compared to the prior year's reported rates because there can be no direct comparison from the 2020 audit tool to the 2019 audit tool.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS Performance Measures (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contracts (Article 9) dated July 2019 and January 2020. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/2019 and 1/1/2020 (Group C) and existing MMC members enrolled in MLTSS between 7/1/2019 and 1/1/2020 (Group D), the 2020 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2019) and continuously enrolled with the MCO in MLTSS through 2/29/2020. A minimum of 100 files were to be reviewed and abstracted across all three groups. An oversample was selected for the MCO to replace any excluded files. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample.

Across all plans, the total NJ weighted average for the 7/1/2019 to 2/29/2020 audit results for Groups C, D and E ranged from 40.0% for PM #9a Member's Plan of Care is amended based on change of member condition, to 96.8% for PM #16 Member training on identifying/reporting critical incidents.

In addition to the MLTSS HCBS Care Management chart review audit, in 2020 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. The Care Management assessment covered the period from July 1, 2019 to June 30, 2020. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents, if their Care Management documentation differed between MLTSS and

FIDE SNP/MLTSS. Interviews were held with key MCO staff via WebEx during July 2020 to review post-offsite evaluation of documentation and offsite activities.

There are 10 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 90% to 100% in 2020.

2020 MLTSS Nursing Facility Care Management Audits

Due to the COVID-19 pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

Conclusion and MCO Recommendations

Chapter 5 of this report provides a summary of strengths, opportunities for improvement, and recommendations for ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. These evaluations are based on the EQRO's review of MCO performance across all activities evaluated during the review period.

CHAPTER 1 – INTRODUCTION

The NJ DMAHS provides healthcare benefits to children and adults with low-to-moderate incomes. DMAHS purchases medical care coverage through contracts with MCOs. The MCOs receive a fixed, prospective, monthly payment for each enrollee of the NJ FamilyCare Managed Care Program. The NJ FamilyCare Managed Care Contract specifies the compliance requirements that must be maintained for finances, service delivery, quality-of-care terms and conditions. To ensure ongoing communication and to discuss contract issues, DMAHS and the MCOs meet throughout the year.

DMAHS has contracted with IPRO to serve as its EQRO. As a part of this contract, IPRO assesses MCO 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 MCO activities for the period from January 2020 through December 2020.

Background

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. As per DMAHS, as of December 2020 there were approximately 1,837,833 individuals enrolled in MMC and the number increased from 1,586,799 in December 2019 (**Table 1**). Of the 1,877,833 individuals enrolled in MMC, 54,928 were receiving MLTSS services as of December 2020. More than 92% of managed care eligible beneficiaries receive services through the managed care program.

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

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

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in January 2020–December 2020. **Table 1** presents respective enrollment figures in December 2019 and December 2020.

Table 1: 2019–2020 MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2019	December 2020	December 2019	December 2020
Aetna Better Health of New Jersey	ABHNJ	65,643	106,834	3,806	4,734
Amerigroup New Jersey, Inc.	AGNJ	187,882	237,211	8,315	9,259
Horizon NJ Health	HNJH	841,457	1,019,574	20,893	20,957
UnitedHealthcare Community Plan	UHCCP	418,378	374,357	9,901	8,379
WellCare Health Plans of New Jersey, Inc.	WCHP	73,439	99,857	10,608	11,599
	Total	**1,586,799**	**1,837,833**	**53,523**	**54,928**

[1]Managed Long Term Services and Supports (MLTSS) members are included in the December 2019–2020 Medicaid enrollment figures.
Source: DMAHS

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid including MLTSS-eligible enrollment for December 2019 and December 2020 in relation to the entire NJ MMC population.

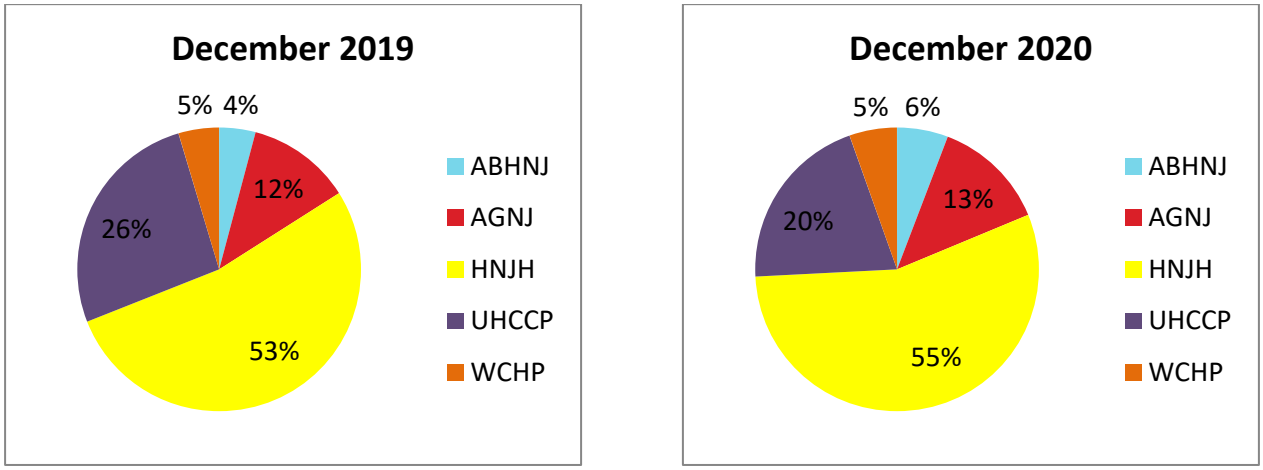

Figure 1: 2019–2020 Medicaid Managed Care Enrollment by MCO. Enrollment in MMC for each MCO reported in **Table 1** as of December 2019 (left panel) and December 2020 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (light blue); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (yellow); UHCCP: UnitedHealthcare Community Plan (purple); WCHP: WellCare Health Plans of New Jersey, Inc. (orange). Percentages may not add to 100% due to rounding.

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

Table 2: 2020 EQR Activities by MCO

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

EQR: external quality review; MCO: managed care organization; PM: performance measure; MLTSS: Managed Long Term Services and Supports; PIP: performance improvement project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: care management; HCBS: Home and Community Based services; ISCA: Information Systems Capabilities Assessment.

Purpose and Objectives

The purpose of this QTR is to: 1) discuss the results of the quality assessments performed during 2020 in accordance with the BBA [Subpart E, 42 CFR, Section 438.364], 2) review the strengths and weaknesses of each MCO, 3) provide recommendations for performance improvement, and 4) establish a foundation for enhancing the quality-of-care services provided to publicly funded programs in NJ. This report provides comprehensive insight about the performance of the State's MCOs on key indicators of healthcare quality for NJ FamilyCare Managed Care enrollees.

External Quality Review Activities

In accordance with the BBA, IPRO conducts EQR activities for DMAHS to ensure enrollees receive quality and timely healthcare from MCOs. EQR is conducted to analyze and evaluate aggregated information on the timeliness, quality, and access to healthcare services that a health plan provides to enrollees. As an EQRO, IPRO meets competency and independence requirements prescribed by the BBA.

Each year, DMAHS (or IPRO, as its EQRO) must conduct three mandatory EQR-related activities for each contracted MCO. **Table 3** describes these required activities.

Table 3: Mandatory EQR-Related Activities

Mandatory EQR Activity	Description
Conduct a review of MCO compliance with federal and State standards established by DMAHS	Following the terms of the NJ FamilyCare Managed Care Contract, IPRO conducted an *Annual Assessment of MCO Operations*. This review examined the MCO's ability to demonstrate – through documentation, interviews, and file reviews – its ability to effectively operationalize the quality requirements of its Contract with DMAHS.
Validate performance measures (PMs)	IPRO assessed the MCOs' processes for calculating and reporting PMs, reported the results of the review, and prepared rate tables and analysis of PM results.
Validate performance improvement projects (PIPs)	Through an iterative process, IPRO examined PIPs to ensure that they were designed to achieve, through ongoing measurements and intervention, significant improvement of the quality of care rendered, sustainable over time, resulting in a favorable effect on health outcomes and/or enrollee satisfaction.

In addition, IPRO is currently conducting one clinical focused study and one non-clinical focused study, and fielded the 2020 CAHPS survey for the Medicaid population. IPRO also completed Core Medicaid and MLTSS HCBS CM audits to evaluate the effectiveness of the MCOs' Core Medicaid and MLTSS CM programs.

MCO Strength and Weakness Evaluation

One of the purposes of this report is to identify strengths and weaknesses, and make recommendations to help each MCO improve care delivery and health services. Understanding these strengths and weaknesses helps assess an organization's readiness to take on new tasks, identify initiatives that match the MCO's skills, and recognize areas where additional training or resources are necessary. IPRO references both current and past performance, trends, benchmarks, and comparisons, along with specific DMAHS goals and targets to make these determinations. Based on this evaluation, IPRO presents DMAHS with a high-level commentary on the direction of each MCO's quality improvement programs and offers advice on facilitating positive change and further improving the care and services provided to enrollees of NJ FamilyCare Managed Care.

Strengths

An MCO's strengths are the valuable resources and capabilities it has developed or acquired over time, which are seen as distinguishing characteristics. An MCO significantly exceeding the national average for a measure would be considered a strength.

Weaknesses

An MCO's weaknesses are those resources or capabilities of an organization that are deficient and viewed as shortcomings in its ability or performance. IPRO identifies an organization's resource or capability as a weakness when that entity is not compliant with provisions of the NJ FamilyCare Managed Care Contract, federal and State regulations, or it performs substantially below both DMAHS' and/or enrollees' expectations of quality care and service. An example of a weakness is a HEDIS PM rate below the national average.

Components of Care: Quality, Access, and Timeliness

IPRO used 2020 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

- ***Quality*** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through healthcare services provided, which are consistent with current professional knowledge.

- ***Access*** is the timely use of personal health services to achieve the best possible health outcomes.[1]

- ***Timeliness*** is the extent to which care and services are provided within the periods required by the NJ FamilyCare Managed Care Contract, federal regulations, and as recommended by professional organizations and other evidence-based guidelines. Timely interventions improve the quality of care and services provided as well as enrollee and practitioner satisfaction. Timeliness refers to the period during which an enrollee obtains needed care. Timeliness of care is influenced by access to services, which can affect utilization of care, including appropriate care and over- or under-utilization of healthcare services.

[1] Access to Health Care in America. Institute of Medicine (IOM); 1993.

CHAPTER 2 – STATE INITIATIVES

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

This chapter provides information on initiatives that DMAHS is undertaking to improve quality of care and information technology. DMAHS has been active in the following State Initiatives: Autism Spectrum Disorder; Behavioral Health/Substance Use Disorder Services; Electronic Visit Verification; Maternal/Child Health; New Jersey Delivery System Reform Incentive Payment; Quality Improvement Program-NJ; Health Information Technology (HIT); Medicaid Information Technology Architecture Project; Medicaid Innovator Accelerator Program; Community Based Care Management Demonstration; and National Core Indicators - Aging and Disabilities (NCI-AD). To implement our vision, New Jersey has focused on providing all of our members with quality care and services through increased access and appropriate, timely utilization of health care services. The goals of our Quality Strategy, which include to improve timely, appropriate access to primary, preventative, and long term services and supports for adults and children; to improve the quality of care and services; to promote person-centered health care and social services and supports; and to assure member satisfaction with services and improve quality of life, guide the below initiatives in direction and scope.

Autism Spectrum Disorder (ASD)

Effective January 1, 2020 NJ FamilyCare added a wide array of new and existing services to treat children with Autism Spectrum Disorder (ASD). Services that were provided by the managed care plans for diagnoses outside of ASD included physical, occupational, and speech therapy; sensory integration; and communication assistive devices and services. Now, the managed care plans must include these services for children with autism. Other behavioral health services were provided by the Children's System of Care (CSOC) within the Department of Children and Families (DCF). These services included skill acquisition and capacity building services which would continue to be provided by CSOC through fee-for-service. Newly enrolled children with moderate to severe autism are eligible to apply for these and other CSOC services intended to support families and ameliorate their condition. As a result of this split responsibility for services, the managed care plans work with CSOC's care management organizations to provide these services in a coordinated and cooperative fashion. As a result, there is no wrong door as families are referred to any service designed to meet their child's identified needs. To further improve the benefit, new services were added or enhanced. Applied Behavior Analysis (ABA), was initially offered under the 1115 Comprehensive waiver as a pilot but had significant limitations. Only a small number of children were able to access this benefit. The new ABA benefit has expanded access to all children diagnosed with ASD under the age of 21 and removed all barriers to service. Since New Jersey has one of the highest per capita rates of autism in the country, managed care has been tasked with expanding the existing provider network required to meet anticipated demands for this service. In addition, NJ FamilyCare became the first Medicaid program to offer Developmental Individual-based Relationship (DIR) Model and other developmental treatment services for children with ASD based on promising new research that has shown the potential benefit of these services. All these services are now part of an Early Periodic Screening Diagnostic and Treatment (EPSDT) comprehensive benefit required by the Centers of Medicare & Medicaid Services (CMS) to expand options and provide family choice.

Behavioral Health/Substance Use Disorder Services

As of July 1, 2019, NJ FamilyCare began providing coverage of peers for substance use disorder (SUD) treatment provided in an independent clinic that is licensed to provide substance use services. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), Certified Peer Recovery Specialist (CPRS) workers who have been successful in the recovery process and can help others with SUD through shared understanding, respect, and mutual empowerment. Peers have been shown to help people become and stay engaged in the recovery process, thereby reducing the likelihood of a relapse. CPRS services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process.

Effective July 1, 2020, NJ FamilyCare began coverage of Substance Use Disorder (SUD) care management services. Care management is a behavioral health service intended to support NJ FamilyCare beneficiaries who have SUD with complex physical or psychosocial needs. Care managers assist beneficiaries as they transition throughout the SUD continuum of

care by matching their perceived needs with available resources and then assisting them to access care. Care managers work with beneficiaries to implement strategies that prevent opioid substance misuse by guiding the treatment team to process identified tasks. To accomplish this, care managers build collaborative relationships with non-opioid treatment providers to address identified needs.

Electronic Visit Verification

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

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

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

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

Maternal/Child Health Initiatives

Aligning with the NurtureNJ campaign of First Lady Tammy Murphy, NJ enacted legislation in recent years to improve the state's maternal and infant health outcomes—with a special focus on racial disparities. Many of these laws expanded services under NJ FamilyCare or added stipulations on reimbursement of maternity-related services. Our 2020 Maternal/Child Health Initiatives were focused on implementation of those laws, including:

- Centering Pregnancy is now a covered NJ FamilyCare benefit (see NJ P.L.2019, c.237). Centering Pregnancy is an evidence-based model of group prenatal care accredited by Centering Healthcare Institute. It provides the same standard of care as traditional models of prenatal care delivery, while also providing peer support and greater access to the clinician. This initiative was effective December 2019.

- Doula care is now a covered NJ FamilyCare benefit (see NJ P.L.2019, c.85). Doulas are a new NJ FamilyCare provider type. They provide non-clinical emotional, physical, and informational support throughout the perinatal period. Doulas do not replace perinatal care by an obstetric clinician, but doula care is an evidence-based intervention that can improve birth-related outcomes and the birth experience. This initiative was effective January 2021.

- Reimbursement of prenatal care for the pregnant member covered by NJ FamilyCare is contingent on the completion of a Perinatal Risk Assessment PRA Plus form (see N.J. P.L.2019, c.88). A provider's completion of the PRA Plus First Visit, Follow Up, and Third Trimester forms are newly-reimbursable services. The PRA Plus form is a uniform screening tool that aids the provider in identifying the member's medical and social needs, supports our Medicaid MCOs in pregnancy risk stratification, and facilitates referrals for some Community Based

resources available through the state's Central Intake system. In 2020, the PRA Plus form was updated to include COVID-19-related questions. This initiative was effective January 2021.

- NJ FamilyCare ended reimbursement of labor and delivery-related professional and facilities claims associated with Early Elective Deliveries (see N.J. P.L.2019, c.87). Early elective deliveries are medically-unnecessary C-section and inductions prior to 39 weeks. This initiative was effective January 2021.

New Jersey Delivery System Reform Incentive Payment (NJ DSRIP)

The New Jersey Delivery System Reform Incentive Payment (NJ DSRIP) program was one component of the New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS). DSRIP was a demonstration program designed to result in better care for individuals, better health for the population, and lower costs by transitioning hospital funding to a model where payment was contingent on achieving health improvement goals. Hospitals were qualified to receive incentive payments for implementing quality initiatives within their community and achieving measurable, incremental clinical outcome results demonstrating the initiatives' impact on improving the New Jersey health care system. The program was initially a five-year program but was approved for extension by CMS in July 2017. The NJ DSRIP program ended on June 30, 2020.

Quality Improvement Program – New Jersey (QIP-NJ)

To support continued population health improvement across New Jersey following the conclusion of the Delivery System Reform Incentive Payment (DSRIP) program on June 30, 2020, the State had planned to implement a program promoting the health of NJ's Medicaid population through performance-based payments focused specifically on improvements for the maternal health population and the behavioral health populations. QIP-NJ was proposed to begin on July 1, 2020, pending CMS approval. However, New Jersey, like many other states across the country, has been managing the critical response to the COVID-19 public health crisis. The impact this virus has had on the health system has been deep and far ranging, and as such, the State delayed the implementation of QIP-NJ by one year to July 1, 2021 and extended the end date of the program to June 30, 2024. The program is currently pending CMS approval.

In the interim year, New Jersey has been approved by CMS to administer a time-limited directed payment to support the financial stability of acute care hospitals. The interim time-limited directed payment, known as the QIP "Bridge" payment, was submitted via a Section 438.6(c) Preprint by DOH and DHS earlier this summer. The payment received CMS approval on September 17, 2020. In compliance with 438.6(c)(2)(i)(A), New Jersey will require each of the state's Medicaid Managed Care Organizations (MMCOs) to issue a per diem add-on payment to hospital inpatient claims across several proposed classes of providers. The State has proposed two semi-annual payments (P1: 03/2021, P2: 9/2021) made by the state's MCOs to each hospital. MCOs would receive 50% of the total amount available for distribution for each pool at the close of each utilization period. Funds originally programmed for QIP-NJ for July 2020-June 2021 (SFY2021) will be used as the source of funding for this investment.

Health Information Technology and the Medicaid Enterprise System

DMAHS continues to recognize the critical role of health information technology (HIT) as a transformation enabler. Current challenges in health system integration arising from information silos have impeded care coordination and resulted in duplication of services, medical errors, and administrative inefficiencies. Meaningful investment in the IT infrastructure will serve to enhance the connection of siloed systems of care to each other, enhance care coordination and quality. In addition, these investments present an opportunity to allow Medicaid providers to better align with workflow barriers and needs at the point of care.

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid including the establishment of an overall Medicaid Enterprise System (MES) strategy encompassing IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E) and the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user

experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Management Information System

The MMIS is an important component of program operations that is vital to advancing the goals of DMAHS and other agencies that comprise the Medicaid enterprise to provide services that are cost-effective and result in high quality outcomes.

With guidance from CMS, DMAHS is currently modernizing the MMIS. The modernization strategy includes leveraging the current MMIS as the modernization platform by deploying enhancements to its existing functions and capabilities. In addition, the strategy is also to identify MMIS modules and processes that will be modernized, such as system integrator, drug rebate and provider management. The goal of the modernization project is to provide DMAHS with the system infrastructure, technical capabilities, and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation. The new system, referred to as the MMIS Modernization, will help ensure that members receive quality, coordinated, and person-centered health services, that programs are effectively administered with the help of decision support tools, and that fraud, waste, and abuse are prevented, detected, and addressed. The MMIS-M will enable NJ to achieve program goals that are critically intertwined with health information technology and electronic exchange of data to improve health outcomes and control program costs.

NJ FamilyCare Integrated Eligibility System

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

The NJ FamilyCare IES continues to utilize modular services that enhances the client and worker experience. The MAGI in the Cloud software service, designed and maintained by CMS and operated through New England States Consortium Systems Organization (NESCSO) is used to automate MAGI eligibility determination. This service allows all NJ MAGI eligibility and program determinations to be done consistently using one set of rules. NJ FamilyCare is configured to interface with the Federal Data Services Hub (FDSH). The FDSH Account Transfer (AT) functionality was set-up to electronically receive beneficiary accounts determined eligible by the Federally Facilitated Marketplace (FFM) using New Jersey eligibility rules. In addition, the web service known as the Medicaid Eligibility Check was established to allow the FDSH to check if applicants are already NJ FamilyCare beneficiaries. The MEC has avoided thousands of duplicate applications because the FDSH can inform the applicant in real-time that they already have NJ FamilyCare coverage. Through the FDSH, the Social Security Administration (SSA) federal data hub verification was implemented. NJ FamilyCare uses the SSA verification to verify name, date of birth, social security number, citizenship and death status for each household member as well as SS Title II income for all applications received daily.

NJ FamilyCare's address verification is another modular service that confirms addresses entered in applications are accurate US Postal Service deliverable addresses. This eliminates waste and access to coverage issues created by undeliverable mail. An asset verification system (AVS) was implemented for the Aged, Blind and Disabled (ABD) program that returns client's end-of-month bank account balances for the five-year asset look back. The system provides access to all national, regional, and local banks.

The NJHelps.org Screening Tool launched in 2017 via a joint initiative with the Division of Family Development. NJHelps was developed as a shared online screening tool allowing New Jersey clients a single point of entry to screen eligibility for health coverage (Medicaid), food (Supplemental Nutrition Assistance Program or SNAP) and cash assistance (Temporary Assistance for Needy Families or TANF and General assistance or GA).

In 2018, NJHelps was expanded to include a client portal. NJHelps client portal provides registered NJ FamilyCare applicants online access to application status, ability to upload required documentation and secure electronic notices (e-notices). E-notices are being implemented in phases as notices are added to NJ FamilyCare. E-notices will start with application confirmation and then add missing information, and eligibility determination notices. Additional FDSH enhancements, Verify Lawful Presence (VLP) to validate immigration status and SSA Title II to verify Social Security Income benefits were also developed and deployed in 2018.

Also in 2019, the NJ FamilyCare IES deployed Presumptive Eligibility and is currently implementing electronic Renewals and Redeterminations. These functionalities will only continue to improve eligibility determination processing time in order to provide for the healthcare needs of the most vulnerable beneficiaries in the STATE. In order to streamline and improve eligibility determination processing times, we added functionality to enter "paper applications" into the NJ FamilyCare system. Online entry for "paper applications" is being piloted at select counties. This functionality allows county workers to enter "paper applications" in NJ FamilyCare so they can leverage automated MAGI eligibility determination; NJ FamilyCare program determination; automated verification tools such as SSA, VLP, SSA Title II, asset; and address verification services. Adding "paper applications" to NJ FamilyCare will provide immediate benefit and ensure new system functionality such as Medicaid Eligibility System Upload and automated verification of wages improve processing for all applications.

In the coming year, New Jersey will transition from the Federal Facilitated Marketplace to a State Based Exchange, the NJ FamilyCare IES is currently being prepared and positioned to accommodate the expected increase in application processing and determination to make certain that health care benefits available to those in need.

HITECH and the Promoting Interoperability Program

New Jersey continues to successfully govern and maintain adequate oversight of the Medicaid Promoting Interoperability Program. The State Medicaid Agency administered the incentive payments to the eligible professionals (EP) and hospitals (EH) as well as pursue the initiatives and strategies to promote health care quality and interoperability by facilitating the connections between EPs and other Medicaid providers to promote their use of Electronic Health Records (EHR)/ Health Information exchange (HIE) technologies for the purpose of meeting the Promoting Interoperability Program objectives or formerly Meaningful Use. New Jersey's attestation portal has also been maintained and upgraded throughout the year as needed to keep up with the CMS guidelines for the program.

By leveraging the federally enhanced HITECH funds for HIT strategies, the state provided oversight to the onboarding of the Medicaid providers, hospitals as well as non-hospital facilities to the statewide health information exchange (HIE) infrastructure, the New Jersey Health Information Network (NJHIN). The State plans to continue focus on expanding the connectivity of the providers, practices, hospitals, FQHCs and others to NJHIN in the coming years and has been approved for additional funding to support the HITECH program by CMS. As of September 2019, New Jersey has completed the implementation for the projects related to enhancing the existing architectural and technical capabilities of NJHIN with the intent to advance State's interoperability efforts. The HITECH program will continue to support public health systems enhancements that allow providers to connect to registries to meet their clinical goals and requirements as well as to demonstrate Meaningful Use and receive incentive payments.

The State Medicaid continues to partner with its Regional Extension Center – New Jersey Innovation Institute (NJII) and leverage their expertise to support the ongoing efforts for provider education, outreach and technical assistance in EHR utilization and Meaningful Use attestation under the Medicaid Provider Program.

In 2019, in support of the SUD 1115 demonstration waiver, the HITECH program also operationalized the state-funded Substance Use Disorder Promoting Interoperability Program (SUD PIP) to enable SUD providers to utilize the EHR systems to improve data access and increase interoperability between physical and behavioral health providers. An SUD HIT workgroup was formed to administer and oversee this program including tracking of incentive payments to SUD providers and meaningful utilization of appropriate electronic health record systems. New Jersey being one of the only states that successfully launched and operationalized the SUD Promoting Interoperability program, CMS invited New Jersey to present in national conferences and webinars to share these efforts and strategies with other interested states.

Additionally, New Jersey received approval of enhanced federal funding and has begun pursuing the initiatives to improve connections to the state registries and increase consumer data access for the Federal Fiscal Year 2020-2021.

The HITECH program initiatives discussed above are all updated and submitted to CMS in the State Medicaid Health Information Technology Plan (SMHP). It describes how New Jersey Medicaid will participate in statewide HIE activities and Medicaid's role in the overall New Jersey HIT environment.

Medicaid Innovation Accelerator Program (IAP)

CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting the State's efforts to accelerate new payment and service delivery reforms. The main goal of the initiative is to enhance CMS's wide ranging efforts to improve care by supporting system-wide payment and delivery system reform innovation. CMS is using the IAP to work closely with states, consumers, and health providers on critical issues through technical assistance (TA), tool development, and cross-state and national learning opportunities.

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

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

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

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

A Scope of Work for a VBP initiative was created by the EQRO during 2019 which incorporated MLTSS Performance measures from our HCBS care management audit in addition to PM #13 – MLTSS/HCBS services are delivered in accordance with the Plan of Care, including the type, scope, amount, frequency, and duration. Feedback on the Scope of Work was offered by the coaching team and incorporated into the EQRO'S Scope of Work for this initiative. The TA for the VBP for HCBS ended in July 2019. In 2020, the HCBS VBP initiative continued as an incentive for the MCOs. The top three performing Health Plans were notified of the third year's results of the Managed Long-Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) program, awarding a one-year sliding-scale bonus performance payment based upon data collected by the State's External Quality Review Organization (EQRO).

Community Based Care Management Demonstration

The Community Based Care Management (CBCM) Demonstration project was implemented to provide real time, high touch, in-person care management and intervention for MCO members who are medically and socially complex or high utilizing members. The Demonstration Project was part of the Division's continued efforts to improve quality and health outcomes while managing costs effectively.

Following three years of data collection, the Office of Quality Assurance (OQA) determined that the MCOs' CBCM programs provide a higher level of service within the continuum of care management and should not be a separate program. Members move in to and out of all levels of care management based on their needs. Inclusion of the elements of CBCM allow for a wider range of interventions that are tailored to each member's changing needs; providing the needed level of care management at the right time. The Community Based Care Management demonstration concluded at the end of 2019. Beginning in 2020 Program effectiveness is tracked and trended as part of the contractually established Care Management Monitoring process.

National Core Indicators – Aging and Disabilities (NCI-AD)

The National Core Indicators for Aging and Disabilities© (NCI-AD) are standard measures used across participating states to assess the quality of life and outcomes of seniors and adults with physical disabilities who are accessing publicly-funded services through the Older Americans Act (OAA), Program of All-Inclusive Care for the Elderly (PACE), Medicaid, and/or state-funded programs. The program is coordinated by ADvancing States and Human Services Research Institute (HSRI). NCI-AD data are gathered through yearly in-person Adult Consumer Surveys administered by state Aging, Disability, and Medicaid Agencies (or an Agency-contracted vendor) to a sample of at least 400 individuals in each participating state. NCI-AD data measure the performance of states' long-term services and supports (LTSS) systems and service recipient outcomes, helping states prioritize quality improvement initiatives, engage in thoughtful decision making, and conduct futures planning with valid and reliable LTSS data.

The NCI-AD Adult Consumer Survey is designed to measure outcomes across nineteen broad domains comprising approximately 55 core indicators. Indicators are the standard measures used across states to assess the outcomes of services provided to individuals, including respect and rights, service coordination, care coordination, employment, health, safety, person-centered planning, etc.

New Jersey has participated in this initiative since NCI-AD's first survey year, 2015-2016, to examine publicly funded long-term services and supports (LTSS) programs regardless of funding source: NJ FamilyCare/Medicaid or PACE. Administrators of these programs are anticipating utilizing the data from the NCI-AD project as one of the tools to assess the performance of NJ's publicly funded LTSS programs and how they impact the quality of life and outcomes of service recipients; as well as a tool to ensure choice, person-centered planning and other components of the Home and Community Based Settings (HCBS) rule; and potential use of the data to evaluate Managed Care Organizations (MCO) and quality of services in managed LTSS as well as for cross agency comparison.

In addition, data from the annual project will be used to support New Jersey's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life of LTSS consumers regardless of funding source.

The MACCs (Medical Assistance Customer Centers), PACE (Program of All-Inclusive Care for the Elderly), NJ Hospital Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey, as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy.

State-specific reports for participating states as well as National reports are available for year over year comparison, along with additional information regarding the NCI-AD survey, on the NCI-AD website, www.nci-ad.org .

CHAPTER 3 – SUMMARY OF KEY FINDINGS

This chapter provides a review of key findings from January 2020–December 2020 EQR activities, including the annual assessment of MCO operations, validation of performance measures, validation of PIPs, Core Medicaid care management audits, MLTSS care management audits, focused studies, and CAHPS surveys. ABHNJ, AGNJ, HNJH, UHCCP, and WCHP participated in all of these EQR activities.

2020 Annual Assessment of MCO Operations

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. The Annual Assessment of MCO Operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations.

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

Effective 2019, the State moved to a new annual assessment audit cycle: 2 consecutive years of partial audits followed by 1 year of full audit. If the MCO scores less than 85% in the first partial audit, the MCO will have a full audit the following year. In 2020, partial reviews were conducted for ABHNJ, AGNJ, HNJH, UHCCP and WCHP. The reviews evaluated each health plan on 13 standards based on contractual requirements. Beginning in 2020, the Care Management and Continuity of Care standard with 41 elements were removed from the Annual Assessment Review, and were reviewed and scored independently during the Core Medicaid and MTLSS HCBS Care Management audits. The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2020 is outlined in **Table 4**.

Table 4: 2020 Annual Assessment Type by MCO

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

Assessment Methodology

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

The review consisted of pre-offsite review of documentation provided by the Plan as evidence of compliance with the 13 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and onsite activities. To assist in submission of appropriate documentation, IPRO developed the Annual Assessment of MCO Operations Review Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. The submission guide was provided to the Plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was July 1, 2019 to June 30, 2020.

Following the document review, IPRO conducted an interview via WebEx with key members of the MCO's staff. The interview allowed IPRO to converse with MCO staff to clarify questions that arose from the desk review. The interview process also gave the MCO an opportunity to demonstrate how written documentation is implemented and

operationalized. In addition, IPRO was able to verify whether documented policies and procedures were actually carried out, providing supportive evidence that each MCO understands the provisions of the Contract.

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. Due to the COVID-19 pandemic, the file review timeframe was adjusted to July 1, 2019, to December 31, 2019. Separate file sets were selected to review Core Medicaid and MLTSS requirements. File reviews utilized the eight and thirty file sampling methodology established by the NCQA.[2]

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 Annual Assessment.

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).

Summary of Comparative Results

Table 5 displays a comparison of the overall compliance score for each of the five MCOs from 2019 to 2020. For the review period July 1, 2019–June 30, 2020, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2020 compliance scores from the annual assessment ranged from 93% to 98% (**Table 5**). ABHNJ's compliance score increased from 93% to 97% in 2020; AGNJ's compliance score increased from 95% to 97%; HNJH's compliance score increased from 95% to 98%, UHCCP's compliance score increased from 90% to 93%; WCHP's compliance score remained at 97% (**Table 5**). One standard (Satisfaction) decreased 4 percentage points from an average compliance score of 100% in 2019 to 96% in 2020 (**Table 6**). Two standards (Programs for the Elderly and Disabled and Enrollee Rights and Responsibilities) decreased 2 percentage points from 100% in 2019 to 98% in 2020 respectively (**Table 6**). Average compliance for four standards (Quality Assessment and Performance Improvement, Committee Structure, Credentialing and Recredentialing, and Management Information Systems) remained the same

[2]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.

from 2019 to 2020. Average compliance for six standards showed increases ranging from 2 to 8 percentage points for Access, Quality Management, Efforts to Reduce Healthcare Disparities, Provider Training and Performance, Utilization Management and Administration and Operations (**Table 6**). In 2020, five standards (Quality Assessment and Performance Improvement, Committee Structure, Provider Training and Performance, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for three standards showed decreases ranging from 2 to 4 percentage points for Programs for the Elderly and Disabled, Satisfaction and Enrollee Rights and Responsibilities. In 2020, Access had the lowest average compliance score at 77% (**Table 6**).

Table 5: Comparison of 2019 and 2020 Compliance Scores by MCO

MCO	2019 Compliance %	2020 Compliance %	% Point Change from 2019 to 2020
ABHNJ	93%	97%	+4
AGNJ	95%	97%	+2
HNJH	95%	98%	+3
UHCCP	90%	93%	+3
WCHP	97%	97%	0

Table 6: 2019 and 2020 Compliance Scores by Review Category

Review Category	MCO Average 2019[2]	MCO Average 2020[2]	Percentage Point Change
Access	69%	77%	+8
Quality Assessment and Performance Improvement	100%	100%	0
Quality Management	88%	96%	+8
Efforts to Reduce Healthcare Disparities	92%	96%	+4
Committee Structure	100%	100%	0
Programs for the Elderly and Disabled	100%	98%	-2
Provider Training and Performance	95%	100%	+5
Satisfaction	100%	96%	-4
Enrollee Rights and Responsibilities	100%	98%	-2
Care Management and Continuity of Care[1]	93%	NA	NA
Credentialing and Recredentialing	96%	96%	0
Utilization Management	92%	97%	+5
Administration and Operations	98%	100%	+2
Management Information Systems	100%	100%	0
TOTAL	**94%[3]**	**97%[3]**	**+3**

[1] Care Management and Continuity of Care were removed from the 2020 Annual Assessment Review, and reviewed and scored independently during the Core Medicaid and MTLSS HCBS Care Management audits.
[2] MCO Average is the average of the compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP).
[3] Total is the average of compliance scores listed in **Table 5**.

Figure 2 depicts compliance scores since 2018. Compliance scores for five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) have remained at or above 90% for all three years.

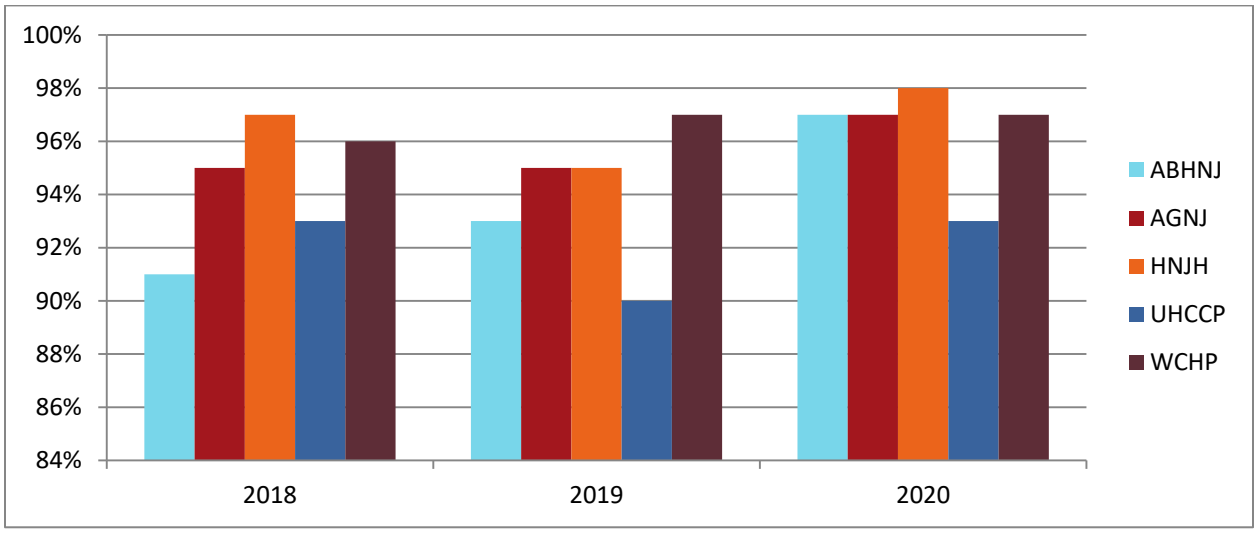

Figure 2: MCO Compliance Scores by Year (2018–2020). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, light blue); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, orange), UnitedHealthcare Community Plan (UHCCP, blue); and WellCare Health Plans of New Jersey, Inc. (WCHP, burgundy) are shown for 2018–2020.

MCO Strengths

The MCO's strengths are the valuable resources, capabilities, and distinguishing characteristics that it has developed or acquired over time. A few of the individual MCO strengths identified as a result of the 2020 annual assessment of MCO operations are listed below:

- The implementation and evaluation of a comprehensive Quality Assessment and Performance Improvement (QAPI) program that meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing quality improvement activities and demonstrates ongoing initiatives.

Opportunities for Improvement

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

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

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

2020 Information Systems Capabilities Assessments (ISCA)

In 2016, the Centers for Medicare and Medicaid Services (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 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 Managed Care Organizations (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.

Assessment Methodology

IPRO worked with DMAHS to customize the ISCA worksheet provided in Appendix A 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 Plan 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.

Table 7: Information Systems Capabilities Assessment (ISCA) Results for 2020

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

MCO	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Standard[1]	Implications of Findings				
Ability of the information system to conduct MCP quality assessment and improvements initiatives.	No implications	No implications	No implications	No implications	No implications
Ability of the information system to oversee and manage the delivery of health care to the MCP's enrollees.	No implications	No implications	No implications	No implications	No implications
Ability of the information system to generate complete, accurate, and timely T-MSIS data.	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Utility of the information system for review of provider network adequacy.	No implications	No implications	No implications	No implications	No implications
Utility of the MCP'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).	No implications	No implications	No implications	No implications	No implications

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

2020 Performance Measures

2020 Core Medicaid Performance Measures

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.

Background

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

Assessment Methodology

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

Evaluation Findings

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) all of the five MCOs demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State. For MY 2019, due to the COVID-19 pandemic, NCQA gave Plans the option to rotate hybrid measures.

In MY 2019 behavioral health facility claims became the responsibility of the MCOs for all Medicaid members. This may have impacted two HEDIS performance measures, Follow-up After Hospitalization for Mental Illness (FUH) and Follow-Up After Emergency Department Visit for Mental Illness (FUM). Horizon showed a significant increase in their eligible population in FUM in MY 2019. It was identified that the significant increase was due to an issue with Horizon's vendor, Inovalon, with regard to the handling of FFS claims. Horizon had to resubmit restated rates for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure. HNJH's restated rates can be found in the Appendix. Following review of the submissions, HNJH submitted rates for these measures which were reviewed and approved by a certified HEDIS compliance auditor (CHCA) at IPRO. These restated rates are not included in the statewide HEDIS grid as they were not submitted as audited HEDIS rates.

UHCCP also had a significant increase in their eligible population in FUM in MY 2019 due to the inclusion of non-DDD and MLTSS members where the MCO was responsible for facility claims.

All of the five MCOs included their non-FIDE Dual Eligible members in the HEDIS submission, where the MCO was also the MCO for the Medicare product, which followed the 2020 NCQA HEDIS guidance. ABHNJ and UHCCP indicated that they have no non-FIDE Dual Eligible members where the Plan is the MCO for the Medicare product. Of the four MCOs with FIDE SNP products, AGNJ and HNJH did not include their FIDE SNP members in the HEDIS submission. AGNJ's accreditation structure does not allow for inclusion of the FIDE SNP population in Medicaid HEDIS reporting. HNJH indicated on their TPL submission that the FIDE SNP members are reported separately, as these members are identified in a separate contract and reported to NCQA/CMS. UHCCP and WCHP included FIDE SNP in their Medicaid HEDIS reporting.

ABHNJ, HNJH, and WCHP excluded members with TPL from their reporting. Amerigroup originally stated that they would not exclude members with TPL from their reporting because at the time of the original TPL submission, Amerigroup reported that commercial members could not be excluded (per specifications). In April of 2020, Amerigroup was able to obtain auditor approval to exclude other health insurance (OHI) from HEDIS. UHCCP did not exclude members with TPL from their reporting.

The following results were noted for the NJ Medicaid average (weighted rates). Overall, rates remained relatively constant between MY 2018 and MY 2019 (with a < 5 percentage point change year over year) for most measures. Significant increases in performance from MY 2018 to MY 2019 are noted below. There were no significant declines in performance from MY 2018 to MY 2019. It should be noted that due to changes to Prenatal and Postpartum Care specification, year-over-year comparisons are not valid.

Improvements in performance from MY 2018 to MY 2019:

- Adolescent Well-Care Visits (AWC) improved by 5.05 percentage points.
- Prenatal and Postpartum Care (PPC)
    - Postpartum Care by 15.64 percentage points.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
    - BMI percentile 12-17 Years improved by 11.64 percentage points.
    - BMI percentile - Total improved by 7.20 percentage points.
    - Counseling for Nutrition - 12-17 Years improved by 6.07 percentage points.
    - Counseling for Physical Activity - 12-17 Years improved by 7.93 percentage points.
- Adult BMI Assessment (ABA) improved by 7.83 percentage points.
- Follow Up Care for Children Prescribed ADHD Medication (ADD)
    - Continuation and Maintenance Phase improved by 6.64 percentage points.
- Follow-Up After Hospitalization for Mental Illness (FUH)
    - 18-64 Years – 30-Day Follow-Up improved by 8.64 percentage points.
    - 18-64 Years – 7-Day Follow-Up improved by 8.39 percentage points.
    - Total – 30-Day Follow-Up improved by 5.85 percentage points.
    - Total – 7-Day Follow-Up improved by 6.91 percentage points.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
    - 18-64 Years – 7-Day Follow-Up improved by 6.61 percentage points.

- Total - 7-Day Follow-Up improved by 6.12 percentage points.

- Risk of Continued Opioid Use (COU)
  - 65+ Years - >= 15 days covered improved (decreased) by 12.36 percentage points.

Table 8: HEDIS 2020 (MY 2019) Performance Measures

HEDIS 2020 (MY 2019) Performance Measure(s)	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Childhood Immunization (CIS)					
Combination 2	63.26%	71.78%	72.02%	58.88%	66.67%
Combination 3	58.64%	67.15%	63.99%	54.01%	61.07%
Combination 9	34.31%	41.85%	35.77%	31.87%	34.79%
Lead Screening in Children (LSC)	67.64%	73.24%	74.70%	80.29%	80.05%
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (W15)	63.99%	69.34%	61.27%	62.53%	68.09%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	73.97%	87.50%	84.95%	76.16%	82.80%
Adolescent Well-Care Visits (AWC)	54.59%	72.63%	67.53%	64.96%	65.05%
Breast Cancer Screening (BCS)	45.97%	55.90%	58.10%	62.26%	62.85%
Cervical Cancer Screening (CCS)	43.07%	62.77%	63.57%	66.91%	57.18%
Comprehensive Diabetes Care (CDC)					
HbA1c Testing	84.41%	86.57%	87.68%	90.50%	90.36%
HbA1c Poor Control (>9.0%)[1]	36.20%	30.02%	38.73%	32.99%	33.80%
HbA1c Control (<8.0%)	51.43%	59.04%	51.94%	58.02%	56.15%
HbA1c Control (<7.0%) for a Selected Population	37.71%	44.87%	38.44%	43.55%	45.26%
Eye Exam	37.46%	58.37%	62.32%	62.90%	60.20%
Medical Attention for Nephropathy	92.47%	90.55%	91.55%	92.30%	93.16%
Blood Pressure Controlled <140/90 mm Hg	55.20%	64.51%	56.34%	59.82%	65.08%
Controlling High Blood Pressure (CBP)	59.37%	63.02%	49.88%	61.31%	60.51%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)[2]	NA	73.85%	79.81%	86.98%	83.33%
Statin Therapy for Patients with Cardiovascular Disease (SPC)[2]					
21-75 years (Male) - Received Statin Therapy	79.22%	79.85%	81.10%	82.25%	79.12%
40-75 years (Female) - Received Statin Therapy	66.67%	78.11%	73.00%	77.13%	78.13%
Total - Received Statin Therapy	74.79%	79.15%	77.53%	79.80%	78.61%
21-75 years (Male) - Statin Adherence 80%	75.41%	71.92%	72.16%	74.88%	72.08%
40-75 years (Female) - Statin Adherence 80%	NA	66.67%	68.91%	72.59%	74.00%
Total - Statin Adherence 80%	74.16%	69.85%	70.81%	73.82%	73.05%
Prenatal and Postpartum Care (PPC)[3]					
Timeliness of Prenatal Care	85.16%	88.32%	80.05%	88.08%	88.32%
Postpartum Care	73.72%	80.05%	75.91%	75.67%	72.02%
Immunizations For Adolescents (IMA)					
Meningococcal	83.52%	89.29%	91.97%	89.05%	84.18%
Tdap/Td	86.89%	94.89%	96.11%	93.19%	92.21%
HPV	20.22%	29.20%	36.98%	29.93%	31.63%
Combination 1	80.15%	88.56%	91.48%	88.32%	82.24%
Combination 2	17.98%	27.49%	35.77%	28.71%	26.52%
Appropriate Testing for Pharyngitis (CWP)[4]					

HEDIS 2020 (MY 2019) Performance Measure(s)	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
3-17 Years	78.18%	84.93%	76.05%	85.57%	73.14%
18-64 Years	49.73%	45.17%	48.43%	55.01%	27.36%
65+ Years	NA	NA	39.42%	24.27%	6.45%
Total	66.56%	73.33%	68.05%	78.04%	54.63%
Appropriate Treatment for Upper Respiratory Infection (URI)[2]					
3 Months-17 Years	92.80%	92.58%	92.44%	90.32%	90.03%
18-64 Years	63.73%	61.14%	63.53%	59.41%	53.78%
65+ Years	65.38%	51.79%	64.11%	46.68%	54.13%
Total	85.68%	86.54%	86.14%	82.98%	79.90%
Chlamydia Screening (CHL)					
16-20 Years	57.32%	63.67%	57.78%	60.85%	61.65%
21-24 Years	67.88%	70.28%	68.81%	67.29%	66.89%
Total	63.52%	66.43%	62.31%	63.53%	63.98%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile - 3-11 Years	86.50%	88.72%	82.86%	77.86%	88.46%
BMI percentile - 12-17 Years	81.02%	91.03%	83.21%	87.25%	89.44%
BMI percentile - Total	84.67%	89.54%	82.98%	81.27%	88.83%
Counseling for Nutrition - 3-11 Years	85.04%	84.59%	75.51%	72.52%	81.20%
Counseling for Nutrition - 12-17 Years	83.21%	84.14%	74.81%	78.52%	79.58%
Counseling for Nutrition - Total	84.43%	84.43%	75.27%	74.70%	80.59%
Counseling for Physical Activity - 3-11 Years	76.64%	78.95%	66.94%	62.60%	71.79%
Counseling for Physical Activity - 12-17 Years	82.48%	82.76%	72.52%	77.18%	73.94%
Counseling for Physical Activity - Total	78.59%	80.29%	68.88%	67.88%	72.61%
Adult BMI Assessment (ABA)	87.10%	96.27%	93.55%	86.37%	97.00%
Follow up care for children prescribed ADHD medication (ADD)					
Initiation Phase	36.59%	37.81%	32.20%	33.76%	42.40%
Continuation and Maintenance Phase	NA	37.63%	34.31%	40.95%	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing[5]					
1-11 Years	NA	37.44%	21.59%	34.25%	30.30%
12-17 Years	45.71%	48.61%	33.05%	48.83%	43.28%
Total	44.26%	44.30%	28.43%	43.95%	39.00%
Antidepressant Medication Management (AMM)[2]					
Effective Acute Phase Treatment	57.81%	53.63%	56.38%	59.27%	57.12%
Effective Continuation Phase Treatment	43.23%	37.94%	41.83%	42.98%	41.84%
Follow-Up After Hospitalization for Mental Illness (FUH)[6,]					
6-17 years - 30-Day Follow-Up	NA	NA	23.08%	NA	NA
6-17 years - 7-Day Follow-Up	NA	NA	5.13%	NA	NA
18-64 years - 30-Day Follow-Up	23.85%	37.84%	45.21%	42.97%	39.24%
18-64 years - 7-Day Follow-Up	15.60%	18.92%	24.66%	27.37%	17.72%
65+ years - 30-Day Follow-Up	NA	NA	NA	26.32%	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	15.79%	NA
Total - 30 Day Follow-Up	23.33%	35.71%	40.21%	39.92%	36.46%
Total - 7 Day Follow-Up	15.83%	16.67%	20.11%	25.21%	17.71%

HEDIS 2020 (MY 2019) Performance Measure(s)	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[6,7]					
6-17 years - 30-Day Follow-Up	NA	NA	22.90%	70.21%	NA
6-17 years - 7-Day Follow-Up	NA	NA	18.56%	61.52%	NA
18-64 years - 30-Day Follow-Up	71.60%	81.97%	28.06%	62.39%	59.32%
18-64 years - 7-Day Follow-Up	64.20%	73.77%	22.42%	54.15%	42.37%
65+ years - 30-Day Follow-Up	NA	NA	NA	53.45%	NA
65+ years - 7-Day Follow-Up	NA	NA	NA	50.00%	NA
Total - 30 Day Follow-Up	73.87%	83.95%	25.66%	64.78%	61.64%
Total - 7 Day Follow-Up	67.57%	75.31%	20.60%	56.52%	45.21%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)[2]					
13-17 years - 30 Day Follow-Up	NA	NA	7.21%	9.09%	NA
13-17 years - 7 Day Follow-Up	NA	NA	6.31%	2.27%	NA
18 and older - 30 Day Follow-Up	18.81%	NA	9.24%	17.94%	9.09%
18 and older - 7 Day Follow-Up	14.85%	NA	6.54%	12.08%	9.09%
Total - 30 Day Follow-Up	18.81%	NA	9.18%	17.72%	9.09%
Total - 7 Day Follow-Up	14.85%	NA	6.54%	11.83%	9.09%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)[2]	80.24%	85.00%	78.49%	88.62%	83.63%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)[2]	62.67%	64.40%	67.16%	66.98%	70.95%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
12-24 months	94.58%	96.73%	96.89%	95.60%	94.25%
25 months - 6 years	89.94%	93.84%	93.30%	91.95%	93.51%
7-11 years	91.19%	96.31%	96.32%	94.54%	96.03%
12-19 years	89.43%	94.26%	94.63%	92.56%	93.88%
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
20-44 Years	68.68%	77.06%	81.29%	80.42%	73.84%
45-64 Years	78.03%	84.43%	88.87%	88.44%	87.44%
65+ Years	84.08%	88.52%	91.11%	95.94%	95.82%
Total	72.74%	80.24%	84.63%	85.16%	83.20%
Medication Management for People With Asthma (MMA)					
5-11 Years - 50% Compliance	NA	60.68%	60.27%	57.31%	61.84%
5-11 Years - 75% Compliance	NA	34.64%	36.21%	29.50%	31.58%
12-18 Years - 50% Compliance	NA	59.52%	58.00%	56.56%	46.81%
12-18 Years - 75% Compliance	NA	33.56%	34.02%	31.70%	14.89%
19-50 Years - 50% Compliance	72.55%	68.34%	67.62%	64.40%	58.87%
19-50 Years - 75% Compliance	41.18%	47.38%	47.57%	40.88%	30.50%
51-64 Years - 50% Compliance	55.88%	72.45%	73.79%	73.60%	69.05%
51-64 Years - 75% Compliance	52.94%	51.32%	54.79%	51.73%	47.62%
Total - 50% Compliance	61.31%	65.14%	64.93%	62.41%	61.28%
Total - 75% Compliance	40.15%	41.68%	43.22%	37.69%	34.36%
Asthma Medication Ratio (AMR)					
5-11 Years	66.67%	67.65%	70.70%	70.46%	65.22%
12-18 Years	38.71%	62.29%	60.26%	62.09%	49.12%

HEDIS 2020 (MY 2019) Performance Measure(s)	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
19-50 Years	45.00%	49.92%	55.59%	56.03%	47.87%
51-64 Years	50.00%	48.61%	56.20%	54.44%	46.45%
Total	48.97%	56.32%	60.28%	60.62%	50.58%
Annual Dental Visit (ADV)					
2-3 Years	43.11%	46.25%	52.44%	53.71%	55.60%
4-6 Years	60.08%	66.36%	72.07%	74.16%	69.49%
7-10 Years	62.20%	69.84%	75.82%	77.55%	71.86%
11-14 Years	61.04%	66.33%	73.84%	74.87%	68.06%
15-18 Years	51.06%	58.22%	66.13%	65.76%	59.63%
19-20 Years	35.95%	42.89%	50.21%	50.91%	40.81%
Total	55.04%	61.84%	69.04%	70.05%	64.30%
Use of Opioids at High Dosage (HDO)[1]	17.23%	13.94%	11.50%	10.30%	8.41%
Use of Opioids From Multiple Providers (UOP)[1]					
Multiple Prescribers	28.43%	16.91%	20.29%	13.01%	13.46%
Multiple Pharmacies	9.27%	1.70%	3.15%	2.30%	2.47%
Multiple Prescribers and Multiple Pharmacies	5.43%	0.74%	1.71%	1.10%	1.24%
Risk of Continued Opioid Use (COU)[1]					
18-64 years - >=15 Days covered	3.32%	3.04%	12.15%	7.26%	8.23%
18-64 years - >=31 Days covered	2.03%	2.10%	5.36%	4.51%	5.27%
65+ years - >=15 Days covered	NA	3.80%	29.13%	20.85%	16.34%
65+ years - >=31 Days covered	NA	0.00%	9.45%	10.80%	8.17%
Total - >=15 Days covered	3.39%	3.05%	12.36%	8.54%	9.31%
Total - >=31 Days covered	1.99%	2.06%	5.41%	5.11%	5.66%
Plan All-Cause Readmissions (PCR)[8]					
Index Stays per Year - 18-44	13.25%	9.45%	10.64%	10.30%	9.79%
Index Stays per Year - 45-54	14.21%	10.78%	12.99%	11.40%	9.77%
Index Stays per Year - 55-64	14.95%	11.75%	12.94%	11.89%	12.64%
Index Stays per Year - Total	13.91%	10.51%	11.96%	11.05%	10.78%
Observed-to-Expected Ratio	1.3076	1.0347	1.2591	1.1208	1.0896
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)[9]					
Total - Total Member Months	331.61	362.81	391.03	446.54	503.8
Dual Eligibles - Total Member Months	495.67	177.73	586.31	986.78	878.30
Disabled - Total Member Months	540.87	583.62	631.47	590.99	1,211.57
Other Low Income - Total Member Months	317.33	345.09	369.94	400.44	400.50
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)[9]					
Total - Total Member Months	55.32	49.24	62.92	50.84	60.75
Dual Eligibles - Total Member Months	38.32	56.64	69.21	78.89	89.29
Disabled - Total Member Months	84.09	80.69	102.3	80.79	78.27
Other Low Income - Total Member Months	53.98	46.71	59.38	46.58	55.96

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

[2] PBH, SPC, URI, AMM, FUA, SSD, and SAA are new measures this year.

[3] Due to changes to this measure for both prenatal and postpartum care, year-over-year comparisons are not valid.

[4] Age bands for CWP were expanded this year.

[5] Age bands for APM were combined this year for the 1-11 age band so no direct comparison can be made to MY 2018.

[6] In MY 2019 behavioral health facility claims became the responsibility of the MCOs for all Medicaid members. This may have impacted two measures [Follow-up After Hospitalization for Mental Illness (FUH) and Follow-Up After Emergency Department Visit for Mental Illness (FUM)].
[7] Horizon showed a significant increase in their eligible population in FUM in MY 2019. Horizon had to resubmit restated rates for the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure.
[8] PCR's rate is based on observed count of 30-day readmission/count of index stays, and the ratio is observed-to-expected ratio with risk adjustment. For PCR, a lower ratio is indicative of better performance.
[9] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance.
Designation N/A: For non-ambulatory measures, indicates that MCO had a denominator less than 30. For ambulatory measures, indicates that the MCO had 0 member months in the denominator.
Designation NR: Indicates that MCO did not report for the measure.

2020 New Jersey State-Specific Measures and Core Set Measures

2020 New Jersey State-Specific Measures

The AAP and CAP measures were removed from the report, as the State no longer requires that these measures be broken out by subpopulations. The Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit) is a custom measure.

2020 New Jersey Core Set Measures

DMAHS requested the MCOs to submit six Core Set Measures in 2019: Developmental Screening in The First Three Years of Life (DEV-CH), Diabetes Short-Term Complications Admission Rate (PQI01-AD), Contraceptive Care Postpartum Women ages 15-20 (CCP-CH), Contraceptive Care All Women ages 15-20 (CCW-CH), Contraceptive Care Postpartum Women ages 21-44 (CCP-AD), and Contraceptive Care All Women Ages 21-44 (CCW-AD). MY 2019 is the first year reporting the Contraceptive Care measures.

1. For MY 2019 Amerigroup, Horizon, United, and WellCare included FIDE SNP dual members in the Preventive Dental visit measure. Aetna did not have any enrollment in a FIDE SNP Product.
2. Aetna reported an increased eligible population and improved rates for developmental screening. The Plan reported increased focus on large volume providers.
3. Amerigroup's rate for the Developmental Screening measure increased by 6.52 percentage points from the prior year.

Table 9: 2020 (MY 2019) New Jersey State-Specific Performance Measures/Core Set Measures

2020 (MY 2019) NJ-Specific Performance Measures/ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Preventive Dental Visit					
Total - 2-3 Years	42.31%	45.22%	50.58%	53.26%	55.66%
Total - 4-6 Years	58.69%	64.03%	69.67%	73.60%	67.97%
Total - 7-10 Years	59.95%	66.59%	73.07%	76.82%	70.11%
Total - 11-14 Years	58.16%	62.12%	69.90%	73.47%	65.22%
Total - 15-18 Years	46.11%	52.50%	60.19%	63.03%	56.68%
Total - 19-21 Years	29.64%	35.78%	43.38%	47.23%	36.11%
Total - 22-34 Years	27.60%	30.11%	38.37%	39.85%	30.01%
Total - 35-64 Years	29.22%	31.09%	37.16%	38.63%	33.10%
Total - 65+ Years	29.92%	28.26%	29.72%	29.29%	28.98%
Total - Total	36.92%	42.89%	51.14%	52.58%	43.84%
Dual Eligibles - 2-3 Years	NA	NA	NA	NA	NA

2020 (MY 2019) NJ-Specific Performance Measures/ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Dual Eligibles - 4-6 Years	NA	NA	NA	NA	NA
Dual Eligibles - 7-10 Years	NA	NA	NA	NA	NA
Dual Eligibles - 11-14 Years	NA	NA	NA	NA	NA
Dual Eligibles - 15-18 Years	NA	NA	NA	NA	NA
Dual Eligibles - 19-21 Years	NA	31.82%	41.27%	48.84%	NA
Dual Eligibles - 22-34 Years	9.13%	28.95%	39.23%	41.05%	34.00%
Dual Eligibles - 35-64 Years	24.05%	33.06%	39.78%	41.16%	33.40%
Dual Eligibles - 65+ Years	31.15%	28.88%	30.38%	29.90%	32.12%
Dual Eligibles - Total	28.41%	30.11%	34.16%	33.81%	32.39%
Disabled - 2-3 Years	NA	45.13%	46.38%	52.56%	NA
Disabled - 4-6 Years	37.88%	51.95%	61.04%	63.36%	62.50%
Disabled - 7-10 Years	46.84%	50.78%	63.53%	62.70%	51.88%
Disabled - 11-14 Years	50.00%	45.25%	59.65%	59.87%	49.01%
Disabled - 15-18 Years	36.07%	36.92%	52.42%	53.62%	47.95%
Disabled - 19-21 Years	28.33%	23.59%	40.49%	42.72%	35.71%
Disabled - 22-34 Years	28.77%	24.28%	36.54%	39.77%	32.92%
Disabled - 35-64 Years	29.63%	25.90%	31.18%	31.38%	32.67%
Disabled - 65+ Years	20.66%	20.79%	23.97%	22.77%	23.76%
Disabled - Total	29.35%	28.92%	38.37%	39.21%	32.36%
Other Low Income - 2-3 Years	42.56%	45.22%	50.64%	53.28%	56.04%
Other Low Income - 4-6 Years	59.57%	64.43%	69.93%	73.98%	68.12%
Other Low Income - 7-10 Years	60.50%	67.30%	73.53%	77.50%	70.96%
Other Low Income - 11-14 Years	58.46%	63.05%	70.46%	74.19%	66.12%
Other Low Income - 15-18 Years	46.52%	53.48%	60.66%	63.61%	57.20%
Other Low Income - 19-21 Years	29.89%	37.79%	43.69%	47.72%	36.17%
Other Low Income - 22-34 Years	28.43%	31.15%	38.51%	39.77%	29.61%
Other Low Income - 35-64 Years	29.95%	31.68%	37.86%	39.38%	33.20%
Other Low Income - 65+ Years	NA	NA	29.60%	32.08%	NA
Other Low Income - Total	39.41%	47.55%	54.92%	57.79%	47.00%
Developmental Screening					
1 Year Old	34.99%	40.99%	38.23%	28.77%	34.89%
2 Year Old	50.52%	53.43%	48.25%	40.66%	37.80%
3 Year Old	49.83%	49.31%	41.61%	37.46%	34.63%
Total - 1-3 Years	44.77%	48.35%	42.85%	36.08%	35.83%
Diabetes Short-Term Complications Admission (PQI01) - Admissions per 100,000 Member Months					
18-64 Years	11.21	13.28	30.86	11.00	22.85
65 Years and Older	0.00	5.77	34.51	8.59	8.04
Total	10.75	13.14	31.01	10.79	18.13
Contraceptive Care – Postpartum Women[1]					
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 3 days	3.13%	0.56%	1.60%	0.64%	1.52%
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 60 days	26.56%	25.84%	28.02%	31.53%	31.82%
Postpartum Women Ages 15-20 - LARC - 3 days	1.56%	0.56%	0.00%	0.32%	0.00%
Postpartum Women Ages 15-20 - LARC - 60 days	4.69%	6.18%	4.44%	4.14%	3.03%

2020 (MY 2019) NJ-Specific Performance Measures/ Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 3 days	6.02%	6.15%	9.24%	6.25%	6.46%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 60 days	30.32%	32.35%	32.23%	35.34%	30.05%
Postpartum Women Ages 21-44 - LARC - 3 days	0.12%	0.14%	0.12%	0.15%	0.16%
Postpartum Women Ages 21-44 - LARC - 60 days	4.75%	5.25%	4.21%	6.22%	6.62%
Contraceptive Care – All Women[1]					
All Women Ages 15-20 - Provision of most or moderately effective contraception	15.73%	16.11%	17.58%	15.58%	13.25%
All Women Ages 15-20 - Provision of LARC	1.41%	0.96%	0.79%	1.02%	1.04%
All Women Ages 21-44 - Provision of most or moderately effective contraception	23.79%	26.64%	25.41%	26.45%	21.93%
All Women Ages 21-44 - Provision of LARC	2.98%	3.25%	2.43%	3.54%	3.24%

[1] MY 2019 is the first year NJ is reporting the Contraceptive Care measures.
Designation N/A: Indicates that MCO had a denominator of less than 30.
Designation NR: Indicates the rate is not reported based on MCO submissions.

2020 MLTSS Performance Measure Validation

Specifications were updated in 2020 for the July 2020 through June 2021 measurement period for the following PMs:

- PM #4: Timeliness of NF Level of Care Assessment by MCO - Assesses the timeliness of assessments following a referral of an MCO member for MLTSS services. Reported monthly.
- PM #18: Critical Incident Reporting - Assesses the reporting of Critical Incidents by the MCO to the State by category within the reporting period. Reported quarterly and annually.
- PM #20: MLTSS Members Receiving MLTSS Services- Assesses the number of unique MLTSS members receiving MLTSS services during the measurement period. Reported quarterly and annually.
- PM #20a: New MLTSS Members with MLTSS Services Within 120 Days of Enrollment - Assesses the number of unique new MLTSS members receiving MLTSS services within 120 days of enrollment. Reported annually.
- PM #21: MLTSS Members Transitioned from NF to Community - Assesses the number NF MLTSS eligible members transitioning to HCBS during the measurement period. Reported quarterly and annually.
- PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days - Assesses the number of MLTSS eligible members who transitioned from NF to HCBS during the reporting period and returned to NF status within 90 days of the transition to HCBS. Reported quarterly and annually.
- PMs #33, #34 and #41: MLTSS Services Used by MLTSS HCBS Members - Assesses the percent of unique HCBS members using: PCA Services only (PM #33), Medical Day Services only (PM #34), and PCA Services and Medical Day Services Only (PM #41). Reported quarterly and annually.
- PMs #46: MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services - Assesses the number of unique MLTSS HCBS members not receiving MLTSS HCBS, PCA or Medical Day Services. Two rates are produced. The second, PM 46a requires continuous enrollment. Reported quarterly and annually.
- PMs #46a: MLTSS HCBS Members with 60 days continuous enrollment not receiving MLTSS HCBS, PCA or Medical Day Services - Assesses the number of unique MLTSS HCBS members not receiving MLTSS HCBS, PCA or Medical Day Services. Two rates are produced. The second, PM 46a requires continuous enrollment. Reported quarterly and annually.
- PMs #47: Post Hospitalization Institutional Care for MLTSS HCBS Member - Assesses the percent of MLTSS HCBS members who were admitted to a nursing facility or an intermediate care facility within 90 days of discharge of an acute inpatient admission during the measurement period.

Additionally, instructions for reporting the following HEDIS measures were updated and provided to the MCOs:

- PMs #26 and #27: Acute Inpatient Utilization by MLTSS Members (IPU) - Summarizes utilization of acute inpatient (IP) visits for MLTSS members. Two rates are reported: PM#26 HEDIS IPU for MLTSS HCBS members, and PM #27 HEDIS IPU for MLTSS NF members. Reported quarterly and annually.
- PM #28 and PM #29: All-Cause Readmissions of MLTSS Members to Hospital Within 30 Days (PCR) - Assesses the number of acute inpatient stays during the measurement period for MLTSS members that were followed by an unplanned acute inpatient readmission within 30 days of the index discharge date. Two rates are reported: PM#28 HEDIS PCR for MLTSS HCBS members, and PM #29 HEDIS PCR for MLTSS NF members. Reported quarterly and annually.
- PMs #30 and #31: Emergency Department Utilization by MLTSS Members (AMB) - Summarizes utilization of Emergency Department (ED) visits for MLTSS members. Two rates are reported: PM #30 HEDIS AMB for MLTSS HCBS members, and PM #31 HEDIS AMB for MLTSS NF members. Reported quarterly and annually.
- PM #36 and PM #38: Follow-up After Mental Health Hospitalization for MLTSS Members (FUH) - Assesses the percentage of discharges for eligible MLTSS members who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 30 days of discharge. Two rates are reported: PM#36 HEDIS FUH for MLTSS HCBS members, and PM #38 HEDIS FUH for MLTSS NF members. Reported quarterly and annually.
- PMs #42 and PM #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS Members (FUA) - Assesses the percentage of Emergency Department (ED) visits for MLTSS members with a principal diagnosis of Alcohol or Other Drug (AOD) dependence and who had a follow-up visit for AOD within 30 days of the ED visit. Two rates are reported: PM #42 FUA for MLTSS HCBS members, and PM #43 FUA for MLTSS NF members. Reported quarterly and annually.
- PMs #44 and PM #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS Members (FUM) - Assesses the percentage of ED visits for MLTSS members with a principal diagnosis of Mental Illness and who had a follow-up visit for Mental Illness within 30 days of the ED visit. Two rates are reported: PM #44 FUM for MLTSS HCBS members, and PM #45 FUM for MLTSS NF members. Reported quarterly and annually.
- PMs #48 and PM #49: MLTSS members hospitalized for potentially Preventable complications (HPC) - Assesses the rate of inpatient admission and observation stay discharges for eligible MLTSS members for ambulatory care sensitive conditions (ACSC) per 1,000 members. It also measures the risk-adjusted ratio of observed-to-expected discharges for ACSC among members 67 years of age and older. Two rates are reported: PM #48 HPC for MLTSS HCBS members, and PM #49 HPC for MLTSS NF members. Reported annually.
- PMs #50 and PM #51: Follow-up after emergency department visit for MLTSS HCBS/NF members with high-risk multiple chronic conditions (FMC) - Assesses the percentage of emergency department (ED) visits for eligible MLTSS members 18 years and older who have multiple high-risk chronic conditions and had a follow-up service within 7 days of the ED visit. Two rates are reported: PM #50 FMC for MLTSS HCBS members, and PM #51 FMC for MLTSS NF members. Reported annually.
- PMs #52 and PM #53: Care for older adults for MLTSS HCBS/NF members (COA) - Assesses the percentage of eligible MLTSS Members 66 years and older who had each of the following during the measurement year. Rates are reported for two different MLTSS population: PM #52 COA for MLTSS HCBS members, and PM #53 COA for MLTSS NF members. Reported annually.

Measures requiring claims have an 8-month lag from the last date of the measurement period to the reporting period, allowing for a 6-month claim lag, 1-month period for report development and 1 month for reporting. The timeframe for validation of claims based measures for the measurement period July 2019 through June 2020 reports ran through February 2021, which is outside the scope of this report.

Validation Results of MLTSS Performance Measures

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

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2020, IPRO produced an annual report which detailed the annual validation process and results, as well as the results of the monitoring activities. This report also provided annual rates for the July 2018- June 2019 measurement period.

The following results are for the July 2018 through June 2019 measurement period:

- PM #4: Timeliness of NF Level of Care Assessment by MCO
  MCO rates range from 73% to 100%, and the statewide rates remained steady between 93% to 97%.
- PM #18: Critical Incident Reporting
  - [Rate A – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the State at the Total and Category level] MCO rates range from 98.4% to 100%, and the statewide rates remained steady between 99.6% to 100%.
  - [Rate B – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the State within 2 business days at the Total and Category level] MCO rates range from 75.2% to 99.4%, and the statewide rates remained steady between 89.4% to 96.3%.
  - [Rate C – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level] MCO rates range from 92.8% to 100%, and the statewide rates remained steady between 96.9% to 98.9%.
  - [Rate D – The average number of days from the date of occurrence for Critical Incidents in the Numerator of Rate C to the date the MCO became aware of the CI at the Total and Category level] The average days range from 8.1 day to 43.8 days for the MCOs to be aware of the CI. At the statewide level, it took averagely from 13.3 days to 16.6 days throughout the measurement year.
- PM #20: MLTSS Members Receiving MLTSS Services
  The quarterly MCO rates vary from 62% to 87%. Rates for all MCOs except WellCare remain around 80%, while WellCare rates hover around 60%. The statewide rates stayed stable between 75% to 81%.
- PM #21: MLTSS Members Transitioned from NF to Community
  The quarterly MCO rates remain low, from 0.2% to 3.9%, and the statewide rates vary from 0.6% to 3.0%.
- PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days
  The MCO rates vary from 0% to 25%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 4% to 12%.
- PM #24: MLTSS HCBS Members who transitioned from HCBS to NF and remained in NF for more than 180 days
  The MCO rates vary from 43% to 100%. However, many of the reported quarterly denominators are less than 30. The statewide rates range relatively stable, between 85% to 92%.
- PM #25: MLTSS HCBS Members who transitioned from HCBS to NF and returned to HCBS in 180 days or less
  The MCO rates vary from 0% to 58%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 8% to 15%.
- PM #26: Acute Inpatient Utilization by MLTSS HCBS Members
  The quarterly MCO rates vary from 22 to 53 utilization per 1000 member months, and the statewide rates range from 35 to 48 utilization per 1000 member months.
- PM #27: Acute Inpatient Utilization by MLTSS NF Members
  The quarterly rates vary from 9 to 53 utilization per 1000 member months, and the statewide rates range from 26 to 39 utilization per 1000 member months.
- PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days
  The quarterly rates ranges from 10% to 32%, and the statewide rates vary from 14% to 17%.
- PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days
  The quarterly rates ranges from 4% to 29%, and the statewide rates vary from 13% to 18%.
- PM #30: Emergency Department Utilization by MLTSS HCBS Members
  The quarterly rates vary from 14 to 131 utilization per 1000 member months, and the statewide rates stay relatively stable, from 70 to 82 utilization per 1000 member months.
- PM #31: Emergency Department Utilization by MLTSS NF Members: the quarterly rates vary from 5 to 60 utilization per 1000 member months, and the statewide rates stay relatively stable, from 28 to 36 utilization per 1000 member months.
- PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members:

- [PM #33 PCA used only] the quarterly rates ranges from 5% to 30%, and the statewide rates stayed stable between 13% to 16%.
- [PM #34 Medical Day used only] the quarterly rates ranges from 1% to 18%, and the statewide rates stayed stable between 3% to 6%.
- [PM #41 PCA and Medical Day used only] the quarterly rates ranges from 2% to 14%, and the statewide rates stayed stable between 5% to 7%.

o PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members
The quarterly rates ranges from 0% to 83%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 10% to 67%.

o PM #38: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members: the quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are less than 10. The statewide rates range from 0% to 50%.

o PM #39: MLTSS HCBS members with select behavioral health diagnoses
- [Rate 39 – Total MLTSS HCBS Members with Mental Illness or Substance Abuse] the quarterly rates ranges from 15% to 35%, and the statewide rates vary from 19% to 30%.
- [Rate 39a – MLTSS HCBS Members with Substance Abuse Only] the quarterly rates remain low, from 0.6% to 2.6%, and the statewide rates vary from 1.1% to 2.0%.
- [Rate 39b – MLTSS HCBS Members with Mental Illness Only] the quarterly rates ranges from 14% to 30%, and the statewide rates vary from 16% to 25%.
- [Rate 39c – MLTSS HCBS Members with Substance Abuse and Mental Illness] the quarterly rates remain low, from 0.5% to 4.3%, and the statewide rates vary from 0.5% to 4.0%.

o PM #40: MLTSS NF members with select behavioral health diagnoses
- [Rate 40 – Total MLTSS NF Members with Mental Illness or Substance Abuse] the quarterly rates ranges from 31% to 64%, and the statewide rates vary from 40% to 53%.
- [Rate 40a – MLTSS NF Members with Substance Abuse Only] the quarterly rates remain low, from 0.4% to 2.9%, and the statewide rates vary from 0.9% to 1.4%.
- [Rate 40b – MLTSS NF Members with Mental Illness Only] the quarterly rates ranges from 29% to 60%, and the statewide rates vary from 38% to 49%.
- [Rate 40c – MLTSS NF Members with Substance Abuse and Mental Illness] the quarterly rates remain low, from 0.9% to 4.2%, and the statewide rates vary from 1.8% to 3.5%.

o PMs #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS Members
The quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are less than 10. The statewide rates vary from 9% to 14%.

o PMs #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS NF Members
The quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are less than 10. The statewide rates vary from 0% to 50%, while most of the denominators are less than 30.

o PMs #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members
The quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates are relatively stable, varying between 31% to 49%.

o PMs #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members
The quarterly rates ranges from 0% to 100%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates are relatively stable, varying between 26% to 53%.

2020 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the POC. This measure ensures MLTSS HCBS are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration.

A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and black-out period information for these cases. Members were required to be enrolled in MLTSS HCBS with the MCO in the measurement period. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs are also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods).

In 2020, IPRO completed validation of PM #13 for measurement period from July 2018 to June 2019, including POC abstraction, review of claims data files, source code, and blackout period files. After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure their reported claims accurately reflected the claims in their transactional systems.

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

The following are validation results for PM #13 for measurement period from July 2018 to June 2019.

Plan of Care Services Assessed

The list of MLTSS services assessed in this methodology is presented in **Table 10**. MLTSS services were identified in the MLTSS Service Dictionary. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services.

Table 10: MLTSS HCBS Services Assessed for Performance Measure #13

MLTSS Services
Adult Family Care
Assisted Living Services/Programs
Chore Services
Community Residential Services
Home Delivered Meals
Medical Day Services
Medication Dispensing Device Monthly Monitoring
PCA/Home Based Supportive Care
PERS Monitoring
Private Duty Nursing

PM #13 does not assess delivery of HCBS MLTSS services that are not delivered on a routine basis, such as respite care. Respite care is intended to provide temporary relief for informal caregivers when needed, and it is limited to a maximum of 30 days per member per calendar year. Members and their caregivers may not always require or request the full 30 days of respite care, yet the service is typically documented in the POC as 30 days per year. Respite care was, therefore, excluded from this analysis. Other services that occur once, such as vehicle and home modifications, were also excluded.

Performance Measure Methodology

Service data from the POCs were used to construct a timeline of expected services for each recurring service in the POC. The timeline of expected services was structured on a weekly or monthly basis, and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC. Weeks were assigned from the first documented date of service and broken into 7-day intervals. If the end of the service span resulted in a partial week (i.e., if the end date of service did not fall on the last day of the 7-day interval), all days in the partial week were dropped from the timeline. Similarly, for monthly services, timelines were constructed using full months only; partial months at the end of the service span were dropped from the timeline. If there were any black-out periods or planned service discontinuations documented, these were removed from the timeline of expected services.

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

Compliance with PM #13 was based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery had to exceed 95% for each service documented in the POC for each member.

Performance Measure Results

As shown in **Table 11**, a total of 73 records were excluded, resulting in a study population of 477 members across all Plans. Records could be excluded for a number of reasons, including no POC submitted in the file, POCs submitted did not have the necessary information to produce quantifiable expected services, and POCs documented only services that were not evaluated for this measure (e.g., Respite Care or Personal Preference Program).

The total study population is 477, an increase of 30 cases from the 447 cases included in the prior year's measure. PM #13 was not produced for 2018. The prior year referenced in all tables is for 2017. Among the MCOs, Aetna's study population increased the most by 17 cases, from 72 in the prior year to 89 in the current year; United was the only MCO with a decreased study population, dropping from 97 to 89. United and Aetna had the lowest final sample sizes due to the high number of cases with no POC. United had 18 members with no POC submitted in the file, while Aetna had 17 cases with no POC.

Table 11: Results Summary

MCO	Total Sampled	Current Year (2019)		Prior Year (2017)		Change in Study Population from Prior Year
		Total Excluded	Study Population	Total Excluded	Study Population	
Aetna	110	21	89	38	72	17
Amerigroup	110	12	98	19	91	7
Horizon	110	13	97	13	97	0
United	110	21	89	13	97	-8
WellCare	110	6	104	20	90	14
Total	550	73	477	103	447	30

Table 12 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 36.7%, an increase of 4.3 percentage points from the rate of 32.4% for the prior year. It is observed that all MCOs except Amerigroup demonstrated better performance this year: United's compliance rate increased the most, by 12.1 percentage points to 46.1%. For Amerigroup, for all seven services evaluated this year, four services showed decreases in rates (Assisted Living, Home Delivered Meals, Medical Day Services, and PERS), two services had no members who received that service in the prior year (Private Duty Nursing and Medication Dispensing Device), and one service (PCA) showed an increase in the compliance rate. Among the MCOs, Amerigroup had the lowest compliance rate, with a rate of 26.5%. United achieved the highest compliance rate, with a rate of 46.1%.

As noted above, compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must exceed 95% for each service documented in the POC for each member. Of the 477 total members in the denominator, 175 (36.7%) received, on average, 95% of the planned service amount for all services documented in the POC.

Table 12: Compliance Rates

	Current Year (2019)			Prior Year (2017)			
MCO	Denominator	Numerator	Compliance Rate	Denominator	Numerator	Compliance Rate	Change in Rate from Prior Year
Aetna	89	34	38.2%	72	25	34.7%	3.5%
Amerigroup	98	26	26.5%	91	34	37.4%	-10.9%
Horizon	97	37	38.1%	97	31	32.0%	6.1%
United	89	41	46.1%	97	33	34.0%	12.1%
WellCare	104	37	35.6%	90	22	24.4%	11.2%
Total	477	175	36.7%	447	145	32.4%	4.3%

Table 13 shows compliance at the service level for the individual MCOs, while **Table 14** shows compliance at the service level across all Plans. The denominators displayed in **Table 13** and **Table 14** are the number of members who had the indicated service documented in their POC during the measurement period, while the numerators are the number of members whose average service delivery was above the 95% threshold. Note that a member can be represented in more than one service.

Across all Plans, the most common MLTSS Service was PCA/Home Based Supportive Care; of the 270 members who had PCA/Home Based Supportive Care services planned, 121 (44.8%) received, on average, 95% or more of the planned amount. Of the MLTSS Services listed, Assisted Living was associated with the highest proportion of members reaching the 95% average threshold; of the 55 members who had Assisted Living Services/Planned, 42 (76.4%) received, on average, at least 95% of the planned amount.

For services with a denominator greater than or equal to 10, improvements were seen over the prior year. Rates with a denominator less than 10 are listed for reference only. Rates for services for which the denominator is small should be reviewed with caution. The exceptions are PCA/Home Based Supportive Care for Aetna[b1], PERS for Amerigroup[b2] and WellCare[b3], and Medical Day Services and Home Delivered Meals for Amerigroup[b4, b5]. For rates across all Plans, the compliance rate of Home Delivered Meals for services with a denominator of more than 10 increased the most, showing an increase from 29.6% in the prior year to 51.7% in the current year; the performance of Assisted Living Services/Programs improved the least and is the only service with a decreased rate of 1.2 percentage points from 77.6% in the prior year to 76.4% in the current year.

Table 13: Proportion of MLTSS Services at or above the 95% Average Service Delivery Threshold, by MCO

	Aetna				Amerigroup				Horizon				United				WellCare			
Services Evaluated	D	N	2019 %	2017 %	D	N	2019 %	2017 %	D	N	2019 %	2017 %	D	N	2019 %	2017 %	D	N	2019 %	2017 %
Adult Family Care																				
Assisted Living Services/Programs	18	12	66.7%	77.8%[a]	7	5	71.4%[a]	81.0%	10	8	80.0%	77.8%	18	15	83.3%	77.8%	2	2	100%[a]	0.0%[a]
Chore Services																0.0%[a]				
Community Residential Services								0.0%				100%[a]								
Home Delivered Meals	21	9	42.9%	29.6%	26	7	26.9%[b4]	29.2%	32	19	59.4%	37.5%	26	17	65.4%	20.7%	15	10	66.7%	30.4%
Medical Day Services	15	1	6.7%	0.0%[a]	22	3	13.6%[b5]	15.4%	24	6	25.0%	7.7%	10	3	30.0%	9.1%	66	29	43.9%	39.2%
Medication Dispensing Device Monthly Monitoring	1	0	0.0%[a]	0.0%[a]	1	1	100%[a]										1	0	0.0%[a]	
PCA/Home Based Supportive Care	46	20	43.5%[b1]	56.0%	65	20	30.8%	20.9%	55	26	47.3%	41.1%	56	28	50.0%	22.4%	48	27	56.3%	43.5%
PERS Monitoring	43	32	74.4%	55.0%	57	41	71.9%[b2]	77.6%	58	39	67.2%	66.0%	37	22	59.5%	53.6%	54	32	59.3%[b3]	60.5%
Private Duty Nursing	1	0	0.0%[a]	0.0%[a]	1	0	0.0%[a]		3	1	33.3%[a]	0.0%[a]	5	2	40.0%[a]					0.0%[a]

[a] Fewer than 10 members in the Denominator. These rates should be reviewed with caution.

[b1] Both Denominator and Numerator decreased this year: the Denominator decreased from 50 to 46 and the Numerator decreased from 28 to 20. However, there is no statistically significant difference between the 2017 and 2019 rates.

[b2] Both Denominator and Numerator increased this year: the Denominator increased from 49 to 57 and the Numerator increased from 38 to 41. However, there is no statistically significant difference between the 2017 and 2019 rates.

[b3] Both Denominator and Numerator increased this year: the Denominator increased from 43 to 54 and the Numerator increased from 26 to 32. However, there is no statistically significant difference between the 2017 and 2019 rates.

[b4] Denominator increased from 24 to 26, while Numerator stayed the same at 7. There is no statistically significant difference between the 2017 and 2019 rates.

[b5] Both Denominator and Numerator increased this year: the Denominator increased from 13 to 22 and the Numerator increased from 2 to 3. However, there is no statistically significant difference between the 2017 and 2019 rates.

MLTSS: Managed Long-Term Services and Supports; D: Denominator; N: Numerator; PCA: Personal Care Assistant; PERS: Personal Emergency Response System.

Gray shading: Zero Denominator for the Service, so Numerator and rate is not applicable.

Table 14: Proportion of MLTSS Services at or above the 95% Average Service Delivery Threshold, All Plans

Services Evaluated	All Plans						
	2019			2017			Change from 2017
	D	N	%	D	N	%	
Adult Family Care	0	0		0	0		
Assisted Living Services/Programs	55	42	76.4%	85	66	77.6%	-1.2%
Chore Services	0	0		1	0	0.0%[a]	
Community Residential Services	0	0		2	1	50.0%[a]	
Home Delivered Meals	120	62	51.7%	135	40	29.6%	22.1%
Medical Day Services	137	42	30.7%	93	24	25.8%	4.9%
Medication Dispensing Device Monthly Monitoring	3	1	33.3%[a]	1	0	0.0%[a]	33.3%
PCA/Home Based Supportive Care	270	121	44.8%	244	91	37.3%	7.5%
PERS Monitoring	249	166	66.7%	207	132	63.8%	2.9%
Private Duty Nursing	10	3	30.0%	5	0	0.0%[a]	30.0%

MLTSS: Managed Long-Term Services and Supports; D: Denominator; N: Numerator; PCA: Personal Care Assistant; PERS: Personal Emergency Response System.
Gray shading: Zero denominator for the Service, so numerator and rate is not applicable.

2020 VBP MLTSS Service Delivery

VBP MLTSS Service Delivery evaluates delivery of utilized MLTSS services to members compared with services identified in the plan of care (POC), for HCBS members in a VBP program for NJ Medicaid MCOs. The MLTSS utilized services assessed in this methodology are: Home Delivered Meals, Medical Day Care, Personal care Assistance (PCA), and Personal Emergency Response System (PERS). In addition to evaluating delivery of services in accordance with the POC, MCOs are evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS; PM #10: Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment; and PM #11: Plans of Care developed using "person-centered principles".

In 2020, the VBP MLTSS Service Delivery was based on the measurement period from July 1, 2018 to December 31, 2018. A sample of 125 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 were selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems. The Primary Source Verification process occurred in the first quarter of 2021, which is outside the scope of this report.

Authorization data were requested in early 2020 to draw samples. Claims data files, source code, POCs, black-out periods files, and supplemental CM notes were submitted by the MCOs. All of the MCOs passed file validation in early 2021, outside the scope of this report. The project completion is ongoing in 2021.

Performance Measure Methodology

To evaluate delivered MLTSS services compared with services documented in POC, service data from the POCs were used to construct a timeline of expected services for each recurring service in the POC. The timeline of expected services was structured on a weekly or monthly basis, and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC. Weeks were assigned from the first documented date of service and broken into 7-day intervals. If the end of the service span resulted in a partial week (i.e., if the end date of service did not fall on the last day of the 7-day interval), all days in the partial week were dropped from the timeline. Similarly, for monthly services, timelines were constructed using full months only; partial months at the end of the service span were dropped from the timeline. If there were any black-out periods or planned service discontinuations documented, these were removed from the timeline of expected services.

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

Compliance rates for each MLTSS services were based on the average service delivery percentage for members included in each week/month over the measurement period. The review is underway and IPRO is working closely with the MCOs to complete the validation in 2021.

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

Core Medicaid/MLTSS Performance Improvement Projects

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 2020-December 2020, this QTR includes IPRO's evaluation of the April 2020 and August 2020 PIP report submissions, final PIP submission, and Fall 2020 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols.

In 2020, AGNJ submitted their August 2020 final report for the "Preterm Birth Rates" PIP. All MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) submitted project year 2 and sustainability reports for their PIPs relating to "Improving Developmental Screening and Referral Rates to Early Intervention for Children 0-3 years". ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted project year 1 and project year 2 updates for the PIP titled, "MCO Adolescent Risk Behaviors and Depression Collaborative". In September 2020, all five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) submitted a new non-clinical PIP proposal for "Primary Care Provider (PCP) Access and Availability". Due to the impact of COVID-19, Element 5 (Robust Interventions) in the August 2020 PIP submissions by the MCOs was excluded from the total score of the PIP.

AGNJ submitted project year I and project year 2 updates for their PIP, Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population. ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted project year 1 and project year 2 updates for "MLTSS Gaps in Care."

The MCOs participated in a collaborative PIP initiated in the fall of 2018 titled, "MCO Adolescent Risk Behaviors and Depression Collaborative." IPRO's role was to arrange and facilitate an introductory meeting with the MCOs to orient them to the topic, establish the standardized metrics, and determine the lead collaborator/point of contact for the project within each MCO. Following the introductory meeting, IPRO attended subsequent meetings which were scheduled and chaired by the MCOs. The MCOs continue to hold bi-monthly collaborative calls with IPRO and the State.

IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure the PIPs met specific criteria for well-designed projects that meet the CMS requirements as outlined in the EQRO protocols.

Assessment Methodology

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. The review categories are listed below:

Review Element 1:	Topic and Rationale
Review Element 2:	Aim
Review Element 3:	Methodology
Review Element 4:	Barrier Analysis
Review Element 5:	Robust Interventions
Review Element 6:	Results Table
Review Element 7:	Discussion and Validity of Reported Improvement
Review Element 8:	Sustainability
Review Element 9:	Healthcare Disparities (unscored)

IPRO reviewed the Submission Reports and provided suggestions to the MCOs to enhance their studies. IPRO reviewed the September new Non- Clinical Proposals for the five Plans and provided feedback on how to enhance the studies as listed below.

Each of the five MCOs submitted the following PIPs:

ABHNJ

PIP 1: Improving Developmental Screening and Referral Rates to Early Intervention for Children
PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 3: Improving PCP Access and Availability (Non-Clinical –Core Medicaid)
PIP 4: Reduction in ER and IP Utilization Through Enhanced Chronic Disease Management
In 2020, the MCO submitted progress reports for PIP 1, PIP 2, and PIP 4.

AGNJ

PIP 1: Reduction of the Amerigroup Preterm Birth Rate by 5% (Final Report)
PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members (Non-Clinical –Core Medicaid)
PIP 5: Prevention of Falls in the Managed Long Term Services and Supports (MLTSS) Population

PIP 6: Decreasing Gaps In Care In Managed Long Term Services and Supports (MLTSS)
In 2020, the MCO submitted progress reports for PIP 2, PIP 3, PIP 5, and PIP 6.

HNJH

PIP 1: Developmental Screening and Early Intervention in Young Children
PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 3: Increasing PCP Access and Availability for Members with Low Acuity, Core Medicaid Membership Non-Emergent ED Visits (Non-Clinical –Core Medicaid)
PIP 4: Reducing Admissions, Readmissions and Gaps in Services For Members With Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population
In 2020, the MCO submitted progress reports for PIP 1, PIP 2, and PIP 4.

UHCCP

PIP 1: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)
PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 3: Decrease Emergency Room Utilization (Non-Clinical –Core Medicaid)
PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population
In 2020, the MCO submitted progress reports for PIP 1, PIP 2, and PIP 4.

WCHP

PIP 1: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age
PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 3: Medicaid Primary Care Physician Access and Availability (Non-Clinical –Core Medicaid)
PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis
In 2020, the MCO submitted progress reports for PIP 1, PIP 2, and PIP 4.

In July 2020, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed requirements for the September 2020 PIP proposals for new Core Medicaid Non-Clinical PIPS. The training (held via virtual platform due to COVID-19) focused on PIP Development, Implementation, and current PIP issues. The MCOs will continue to submit project updates in April and August progress reports each year.

This report summarizes IPRO's review of the MCOs' progress in their PIPs, their findings, the strength of the interventions, and evidence of improvement for each PIP.

Summary of PIP Performance

PIP Strengths

The MCOs participated in a collaborative PIP initiated in the fall of 2018 titled, "MCO Adolescent Risk Behaviors and Depression Collaborative." In 2020, the Collaborative became more engaged in discovering new avenues to access and monitor the PIP projects as new barriers arose. In the meetings, the MCO's would share ideas reflective of the growth from the previous year and building on new ways of working with the members and providers to monitor what was happening, and gather what information was available. In this manner, each MCO would bring to the Collaborative new questions, ideas, and suggestions for keeping up with the members, keeping providers up to date regarding GAPs in care when possible, and updating the monitoring of PIP data with more explanation when data was not available or not able to be captured as in the previous year. Overall, through the nuances of 2020 with COVID-19, IPRO recognized growth within each MCO for their projects.

Opportunities for Improvement

In 2020, the commonality among the MCO's in the Adolescent Risk Behaviors and Depression Collaborative was the impact of COVID-19, and how to adequately capture data in spite of office closures. Telehealth emerged as the new platform to see and care for members. COVID-19 was the primary subject of discussion during several PIP meetings with the MCOs throughout the year. The MCO's sought guidance, and IPRO provided clarity regarding how information could

be captured in order to focus on helping the members stay safe and healthy. Telecommunications became the main line of communications throughout COVID-19, which was another barrier to monitoring data and understanding outcomes and the impact this virus would have on these projects.

As MCOs continue to monitor and gather data in the midst of COVID-19, the MCO's have gained insight on new ways to look at the barriers, add new ones, align interventions in a meaningful way, and monitor the processes consistently to achieve an outcome which they can explain.

DMAHS Encounter Data Validation

Encounter data validation (EDV) is an ongoing process involving the MCOs, the State, 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 2020, 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 2020, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts.

Focused Quality Studies

Non-clinical Focused Study Pharmacy Claims vs. Encounter Data

In 2020, the EQRO continued the pharmacy audit study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit is to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid MCOs and all four FIDE SNP MCOs. The pharmacy encounter data submitted to DMAHS was reconciled to the corresponding source claim data from the originally adjudicated claims and differences were identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018. The EQRO has selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Medicaid and FIDE SNP MCO. The MCOs have provided the adjudicated claim information and the EQRO is in the process of identifying the discrepancies. The EQRO worked closely with the MCOs and EDMU to review the discrepant data elements. The EQRO scheduled the MCO teleconferences to review the discrepant records during February 2021. The EQRO anticipates completing the Pharmacy audit study by the first quarter 2021.

2020 Maternal Mortality Focused Study

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

Study questions include:

1. What is the total number of pregnancy-associated deaths in the New Jersey Medicaid population during the study period?
2. Of these pregnancy-associated deaths, how many were pregnancy-related?
3. Are there disparities in pregnancy-associated deaths in the New Jersey Medicaid population associated with member demographics or health-related variables such as:

a. race/ethnicity;
b. age at death;
c. medical and behavioral risk factors such as hypertension (pre-pregnancy and gestational), diabetes (pre-pregnancy and gestational), obesity, and smoking;
d. when prenatal care was initiated (i.e., 1st trimester, 2nd trimester, 3rd trimester, or no prenatal care) and the frequency of prenatal visits; and
e. postpartum care on or between the 21st day and the 56th day after delivery of a live birth.

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

The report for this study will be a descriptive report, summarizing the population of focus by the variables listed above. Descriptive information for the larger maternity population using administrative data from encounter claims and eligibility records will be provided.

2020 CAHPS Survey

Results from the HEDIS-CAHPS 5.0H Survey for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following three survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare: Center for the Study of Services (CSS), DSS Research, and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2019 through December 31, 2019, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

The survey drew, as potential respondents, adult enrollees over the age 18 years, who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2020 using a mixed-mode protocol. All five health plans utilized a mail and telephone protocol. ABHNJ and AGNJ implemented a two-wave mail-only protocol, while HNJH, UHCCP and WCHP implemented a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. Additionally, ABHNJ and HNJH offered the option to complete the survey via the internet during the field.

For the adult survey, a total random sample of 8,978 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,350 ABHNJ enrollees, 1,755 AGNJ enrollees, 1,755 HNJH enrollees, 1,620 UHCCP enrollees, and 2,498 WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,548 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 17.6%. Composite results of the adult NJ FamilyCare overall weighted responses for the five MCOs were: 93.2% for how well doctors communicate; 86.9% for customer service; 82.2% for getting needed care; and 78.8% for getting care quickly.

For the child survey, a total random sample of 10,857 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 2,772 ABHNJ enrollees, 2,145 AGNJ enrollees, 1,980 HNJH enrollees, 2,310 UHCCP enrollees, and 1,650 WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,762 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 16.4%. Composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 92.0% for how well doctors communicate; 85.8% for getting care quickly; 85.6% for customer service; and 84.5% for getting needed care.

For the CHIP survey, a total random sample of 2,145 parent/caretakers of CHIP child enrollees was drawn. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample

selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 662 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 31.2%. Composite results of the CHIP NJ FamilyCare overall statewide responses were: 95.9% for how well doctors communicate; 87.4% for getting needed care; 85.8% for getting care quickly; 85.2% for customer service.

Care Management Audits

2020 Core Medicaid Care Management Audits

The purpose of the care management audit was to evaluate the effectiveness of the contractually required care management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established care management requirements to ensure that the services provided to members with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include members under the Division of Developmental Disabilities (DDD) and members under the Division of Child Protection and Permanency (DCP&P). The General Population was not evaluated during the current audit period.

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

In 2019 and 2020, IPRO and the Office of Quality Assurance (OQA) collaborated on revising the NJ EQRO MCO Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited to exclusively 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MCO Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the current review period will not be compared to the prior year's reported rates because there can be no direct comparison from the current audit tool to the previous audit tool. IPRO prepared Audit Tools structured to collect requirement-specific information related to: Outreach, Preventive Services, Continuity of Care and Coordination of Services. The tools included state-specific contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

The audits focused on Outreach, Preventive Services, Continuity of Care, and Coordination of Services for each population. The audit reports contained the findings of IPRO's MY 2019 audit.

Assessment Methodology

IPRO identified the specific populations using enrollment and eligibility; removed the Members with TPL from the DDD and DCP&P Populations; and generated the random sample for each MCO. An off-site desk audit was carried out during March and April 2020 for the DDD and DCP&P Populations. An electronic, standardized data collection tool was used. Following the audit, IPRO aggregated the MCOs' results by population and prepared audit reports. MCOs were not permitted to submit additional information after the audit.

Summary of Audit Performance

Table 15 provides the results for the MCOs. Shaded rates indicate scores that are at or above 90%. The MY 2019 rates across all MCOs, populations, and categories ranged from 69% to 100%. Scores for Outreach ranged from 93% to 100% for all MCOs for all populations. Scores for Preventive Services ranged from 69% to 91% across all MCOs for all populations. Scores for Continuity of Care ranged from 72% to 95% across all MCOs for all populations. Scores for Coordination of Services ranged from 98% to 100% across all MCOs for all populations (**Table 15**).

Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD and DCP&P) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 40 scores (**Table 15**).

ABHNJ, AGNJ and WCHP scored above 90% in 4 out of 8 categories for all populations. HNJH scored at or above 90% in 6 out of 8 categories, and UHCCP scored above 90% in 5 of the 8 categories.

Table 15: 2020 Core Medicaid Care Management Audit Results (MY 2019)

Determination by Category	MCO				
	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
	MY 2019	MY 2019	MY 2019	MY 2019	MY 2019
DDD	n =27	n = 41	n = 68	n = 53	n = 43
Outreach	100%	98%	99%	100%	99%
Preventive Service	69%	80%	77%	73%	73%
Continuity of Care	76%	80%	79%	78%	74%
Coordination of Services	100%	100%	99%	98%	99%
DCP&P	n = 71	n = 89	n = 100	n = 100	n = 21
Outreach	99%	98%	99%	97%	93%
Preventive Service	76%	84%	91%	83%	75%
Continuity of Care	72%	84%	90%	95%	81%
Coordination of Services	99%	99%	100%	100%	100%

DDD: members under the Division of Developmental Disabilities; DCP&P: members under the Division of Child Protection and Permanency.
Gray shading indicates scores at or above 90%.

The following are some of IPRO's key observations and comments following each MCO's CM audit.

ABHNJ

ABHNJ audit results ranged from 69% to 100% across all populations for the four categories.

Overall, the MCO scored at or above 80% in the following review elements:

- Outreach (DDD) (100%)
- Outreach (DCP&P) (99%)
- Coordination of Services (DDD) (100%)
- Coordination of Services (DCP&P) (99%)

Opportunities for improvement for review elements scored below 80% exist in the following elements:

- Preventive Services (DDD) (69%)
- Preventive Services (DCP&P) (76%)
- Continuity of Care (DDD) (76%)
- Continuity of Care (DCP&P) (72%)

Opportunities for improvement in Preventive Services Category for the DDD Population
Aetna should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry should be consistently documented. Aetna should ensure that dental needs are addressed for

all members, particularly members 21 years of age and older. Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.

Opportunities for improvement in Preventive Services Category for the DCP&P Population
Aetna should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of immunizations from a reliable source, such as the PCP, NJ immunization registry, and DCP&P nurse, should be consistently documented. Aetna should ensure that dental needs are addressed for all members. Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. Aetna should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Opportunities for improvement in Continuity of Care Category for the DDD Population
Aetna should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA.

Opportunities for improvement in Continuity of Care Category for the DCP&P Population
Aetna should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

AGNJ

AGNJ audit results ranged from 80% to 100% across all populations for the four audit categories.

Overall, the MCO scored at or above 80% in the following review elements:

- Outreach (DDD) (98%)
- Outreach (DCP&P) (98%)
- Preventive Services (DDD) (80%)
- Preventive Services (DCP&P) (84%)
- Continuity of Care (DDD) (80%)
- Continuity of Care (DCP&P) (84%)
- Coordination of Services (DDD) (100%)
- Coordination of Services (DCP&P) (99%)

Overall, the MCO did not score below 80% for any of the review elements.

HNJH

HNJH audit results ranged from 77% to 100% across all populations for the four audit categories.

Overall, the MCO scored at or above 80% in the following review elements:

- Outreach (DDD) (99%)
- Outreach (DCP&P) (99%)
- Preventive Services (DCP&P) (91%)
- Continuity of Care (DCP&P) (90%)
- Coordination of Services (DDD) (99%)
- Coordination of Services (DCP&P) (100%)

Opportunities for improvement for review elements scored below 80% exist in the following elements:

- Preventive Services (DDD) (77%)
- Continuity of Care (DDD) (79%)

Opportunities for improvement in Preventive Services Category for the DDD Population
Horizon should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, NJ immunization registry, should be consistently documented. Care managers should ensure members 18 years of age and older receive appropriate vaccines. Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. Horizon should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Opportunities for improvement in Continuity of Care Category for the DDD Population

Horizon should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

UHCCP

UHCCP audit results ranged from 73% to 100% across all populations for the four audit categories.

Overall, the MCO scored at or above 80% in the following review elements:

- Outreach (DDD) (100%)
- Outreach (DCP&P) (97%)
- Preventive Services (DCP&P) (83%)
- Continuity of Care (DCP&P) (95%)
- Coordination of Services (DDD) (98%)
- Coordination of Services (DCP&P) (100%)

Opportunities for improvement for review elements scored below 80% exist in the following elements:

- Preventive Services (DDD) (73%)
- Continuity of Care (DDD) (78%)

Opportunities for improvement in Preventive Services Category for the DDD Population
UnitedHealthcare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry should be consistently documented. Care managers should ensure members 18 years of age and older receive appropriate vaccines. Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. UnitedHealthcare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Opportunities for improvement in Continuity of Care Category for the DDD Population
UnitedHealthcare should ensure all members receive a Comprehensive Needs Assessment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

WCHP

WCHP audit results ranged from 73% to 100% across all populations for the four audit categories.

Overall, the MCO scored at or above 80% in the following review elements:

- Outreach (DDD) (99%)
- Outreach (DCP&P) (93%)
- Coordination of Services (DDD) (99%)
- Coordination of Services (DCP&P) (100%)
- Continuity of Care (DCP&P) (81%)

Opportunities for improvement for review elements scored below 80% exist in the following elements:

- Preventive Services (DDD) (73%)
- Preventive Services (DCP&P) (75%)
- Continuity of Care (DDD) (74%)

Opportunities for improvement in Preventive Services Category for the DDD Population
WellCare should ensure members 18 years of age and above receive appropriate vaccines. Care managers should document all aggressive outreach attempts to obtain immunization for members 18 years of age and above. Care Managers should address all dental needs for members 21 years of age and older. WellCare should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Opportunities for improvement in Preventive Services Category for the DCP&P Population
WellCare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of immunizations from a reliable source, such as the PCP, NJ immunization registry, and DCP&P nurse if appropriate, should be consistently documented. Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Opportunities for improvement in Continuity of Care Category for the DDD Population
WellCare should ensure all members receive a Comprehensive Needs Assessment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

In addition to the Core Medicaid Care Management DDD and DCP&P chart review audit, in 2020 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in the submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on January 3, 2020 and received from the MCOs on January 21, 2020. The Care Management assessment covered the period from January 1, 2019 to December 31, 2019. Due to COVID-19 the interviews with the MCOs were delayed. The interviews were subsequently held with key MCO staff via WebEx in July 2020 to review post-offsite evaluation of documentation and offsite activities.

There are 30 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 83% to 90% in 2020. **Table 15a** presents an overview of the results. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for

calendar year 2019 for two populations, namely the enrollees under the Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P).

Table 15a: Summary of Findings for 2020 Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Aetna	30	26	4	**87%**
Amerigroup	30	25	5	**83%**
Horizon	30	25	5	**83%**
United	30	25	5	**83%**
WellCare	30	27	3	**90%**

2020 MLTSS HCBS Care Management Audits

The purpose of the Managed Long Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility, are consistent with professionally recognized standards of care. Effective January 1, 2016, the MLTSS HCBS benefits were made available to FIDE SNP members. Typically, the review period for the annual HCBS audit is from July 1st through June 30th. However, in March 2020 due to the COVID-19 pandemic, Managed Care Organizations (MCOs) were mandated to suspend certain in-person Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle the MCOs would be evaluated only for the period through which they could conduct normal business activities. This meant that the review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/2019 through 2/29/2020. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. For MCOs that did not have at least ten (10) TBI members who met the enrollment criteria, all TBI members were included in the sample.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System and contract references. In 2019 and 2020, IPRO and DMAHS collaborated on revising the NJ EQRO MLTSS HCBS Care Management Audit tool to improve and refine the audit process by eliminating 'not applicable' conditions in the individual audit questions. Audit questions are now limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool where appropriate to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions members represented in the numerator and denominator represent only those who met the specific applicable criteria.

Based on the extensive revisions to the NJ EQRO MLTSS HCBS Care Management Audit tool, it was agreed upon by IPRO and DMAHS that the results in the 2020 review period will not be compared to the prior year's reported rates because there can be no direct comparison from the 2020 audit tool to the 2019 audit tool.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member

needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contracts (Article 9) dated July 2019. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/2019 and 1/1/2020 (Group C) and existing MMC members enrolled in MLTSS between 7/1/2019 and 1/1/2020 (Group D), the 2020 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2019) and continuously enrolled with the MCO in MLTSS through 2/29/2020.

A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. A minimum of 100 files were to be reviewed and abstracted across all three groups. An oversample was selected for the MCO to replace any excluded files. Additionally, for each MCO a random selection of Traumatic Brain Injury (TBI) members was included in the sample. In order to achieve a denominator of 100 members for MLTSS PM #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS), an additional ancillary group of 25 HCBS MLTSS members were randomly selected and abstracted from subgroups C and D.

IPRO reviewers conducted the file reviews over a five-week period offsite. Electronic files were prepared by each MCO for review. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit database, and ongoing communication and coordination among the review team.

Results by Category

Individual MCO compliance rates across all three (3) subgroups ranged from a low of 49.6% for Amerigroup in the Face-to-Face Visits category to a high of 100.0% for Aetna in the Outreach category and 100.0% for Horizon in the Gaps in Care/Critical Incidents category. In review of total scores, one (1) MCO (Horizon) scored above 85% in the Assessment category, two (2) MCOs (Aetna and WellCare) scored above 85% in the Outreach category, two (2) MCOs (Horizon and WellCare) scored above 85% in the Face-to-Face Visits category, two (2) MCOs (Horizon and WellCare) scored above 85% in the Initial Plan of Care (Including Back-up Plans) category, one (1) MCO (Horizon) scored above 85% in the Ongoing Care Management category, and all five (5) MCOs (Aetna, Amerigroup, Horizon, WellCare, and United) scored above 85% in the Gaps in Care/Critical Incidents category. **Table 16** presents the results by Category for each MCO.

Table 16: MLTSS HCBS Care Management Results by Category 2019

Determination by Category 7/1/2019 – 2/29/2020	Aetna				Amerigroup				Horizon				United				WellCare				NJ Weighted Average[1]
	Group				Group				Group				Group				Group				
	C %	D %	E %	Total %	C %	D %	E %	Total %	C %	D %	E %	Total %	C %	D %	E %	Total %	C %	D %	E %	Total %	%
Assessment	100	55.4	90.9	74.0	100	78.4	92.6	81.5	100	92.4	100	94.4	100	69.6	91.2	77.9	100	65.6	88.9	70.4	79.7
Outreach[2]	100	100		100	85.7	80.4		81.5	86.4	74.4		78.5	71.0	65.7		68.2	90.0	85.5		86.2	83.1
Face-to-Face visits	82.1	84.5	69.0	79.4	50.0	49.5	49.6	49.6	87.3	98.3	83.5	91.1	69.7	71.5	74.4	71.9	79.1	93.8	80.2	87.8	76.0
Initial Plan of Care (Including Back-up Plans)	74.9	79.7	88.7	80.3	69.6	66.4	92.7	75.6	97.7	98.7	94.2	96.9	75.8	80.8	87.9	81.8	78.9	88.1	90.2	88.0	84.6
Ongoing Care Management	76.1	71.8	33.3	63.6	78.1	82.8	51.9	74.0	89.8	89.9	72.0	85.2	77.9	79.8	53.3	72.8	74.1	77.8	59.7	72.4	73.8
Gaps in Care/Critical Incidents	98.6	96.3	100	98.4	95.7	99.0	100	98.9	100	100	100	100	86.3	95.8	93.9	92.6	89.5	98.2	97.1	97.0	97.3

[1]The weighted average is the sum of all numerator compliant charts divided by the sum of all charts in the denominator and include all three subpopulations.
[2]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.
Group C - Members New to Managed Care and Newly Eligible to MLTSS.
Group D - Current Members Newly Enrolled to MLTSS.
Group E - Members Enrolled in the MCO and MLTSS prior to the review period.

Performance Measure Results

Table 16a presents a summary based on file review of the MCOs' performance for the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's plan of care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS HCBS plans of care that contain a back-up plan, if required), and #16 (Member training on identifying/reporting critical incidents). Rates were calculated as the number of "Yes" determinations (numerator) divided by the sum of the "Yes" plus "No" determinations (denominator) based on documentation provided for offsite review.

Across all Plans, the total NJ weighted average for the 7/1/2019 to 2/29/2020 audit results for Groups C, D and E ranged from 40.0% for PM #9a Member's Plan of Care is amended based on change of member condition, to 96.8% for PM #16 Member training on identifying/reporting critical incidents (**Table 16a**).

Table 16a: MLTSS HCBS Care Management Audit Performance Measure Results for 7/1/2019 to 2/29/2020

Performance Measure	Group[1]	7/1/19 to 2/29/2020					
		Aetna	Amerigroup	Horizon	United	WellCare	NJ Weighted Average[2]
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[3]	C	43.6%	23.5%	97.1%	43.5%	53.8%	53.3%
	D	59.0%	28.8%	94.4%	55.6%	71.4%	60.8%
	E						
	TOTAL	50.0%	27.8%	95.5%	49.5%	68.9%	58.1%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	C						
	D						
	E	92.3%	100%	100%	100%	85.7%	96.0%
	TOTAL	92.3%	100%	100%	100%	85.7%	96.0%
#9a. Member's Plan of Care is amended based on change of member condition[5]	C	0.0%	N/A	N/A	100%	N/A	50.0%
	D	0.0%	100%	100%	N/A	N/A	66.7%
	E	50.0%	0.0%	0.0%	N/A	N/A	20.0%
	TOTAL	25.0%	33.3%	50.0%	100%	N/A	40.0%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	C	100%	92.9%	100%	90.3%	90.0%	95.8%
	D	92.6%	96.1%	100%	97.1%	96.4%	96.7%
	E	92.3%	100%	100%	95.7%	95.8%	97.1%
	TOTAL	96.4%	96.5%	100%	94.4%	95.5%	96.6%
#11. Plans of Care developed using "person-centered principles"[7]	C	0.0%	50.0%	95.5%	35.5%	90.0%	40.0%
	D	0.0%	13.7%	100%	11.4%	89.1%	48.8%
	E	53.3%	94.3%	100%	55.9%	68.6%	75.1%
	TOTAL	16.0%	47.0%	99.0%	34.0%	82.0%	55.6%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	C	75.9%	11.1%	92.9%	90.0%	77.8%	75.3%
	D	66.7%	18.0%	100%	91.4%	88.9%	71.6%
	E	92.3%	44.4%	78.1%	73.3%	97.1%	78.0%
	TOTAL	78.0%	25.6%	90.9%	84.7%	90.8%	74.5%
#16. Member training on identifying/reporting	C	97.7%	92.9%	100%	80.6%	90.0%	92.5%
	D	92.6%	98.0%	100%	97.1%	98.2%	97.6%

Performance Measure	Group[1]	7/1/19 to 2/29/2020					
		Aetna	Amerigroup	Horizon	United	WellCare	NJ Weighted Average[2]
critical incidents	E	100%	100%	100%	97.1%	97.1%	98.8%
	TOTAL	97.0%	98.0%	100%	92.0%	97.0%	96.8%

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

Based on the reported MLTSS PMs, IPRO made the following key observations for each MCO for the current review period:

ABHNJ

Total results of ABHNJ's 7/1/2019–2/29/2020 MLTSS PMs ranged from 16.0% to 97.0% across all groups for all seven (7) performance measures for the current review period (**Table 16a**).

AGNJ

Total results of AGNJ's 7/1/2019–2/29/2020 MLTSS PMs ranged from 25.6% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 16a**).

HNJH

Total results of HNJH's 7/1/2019–2/29/2020 MLTSS PMs ranged from ranged from 50.0% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 16a**).

UHCCP

Total results of UHCCP's 7/1/2019–2/29/2020 MLTSS PMs ranged from 34.0% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 16a**).

WCHP

Total results of WCHP's 7/1/2019–2/29/2020 MLTSS PMs ranged from 68.9% to 97.0% across all groups for all seven (7) performance measures for the current review period (**Table 16a**).

In addition to the MLTSS HCBS Care Management chart review audit, in 2020 the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the offsite review was requested by IPRO on May 22, 2020 and received from the MCOs on June 12, 2020. The Care Management assessment covered the period from July 1, 2019 to June 30, 2020. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents, if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS. Interviews were held with key MCO staff via WebEx during July 2020 to review post-offsite evaluation of documentation and offsite activities.

There are 10 contractual provisions in this category. Overall compliance scores for the five MCOs ranged from 90% to 100% in 2020. **Table 16b** presents an overview of the results.

Table 16b: Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Aetna	10	9	1	**90%**
Amerigroup	10	9	1	**90%**
Horizon	10	10	0	**100%**
United	10	9	1	**90%**
WellCare	10	10	0	**100%**

2020 MLTSS Nursing Facility Care Management Audits

Due to the COVID-19 pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

CHAPTER 4 – FOLLOW-UP TO QTR RECOMMENDATIONS FROM PREVIOUS QTR

The BBA, Section 42 CFR section 438.364(a)(6), states that the EQRO (IPRO) "must provide an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed MCO-specific recommendations from the IPRO previous QTR, which entailed EQR activities from July 1, 2018 to June 30, 2019. The following is the MCO responses addressing each recommendation. Recommendations are presented in italics with bullets and MCO responses are included verbatim under each recommendation.

ABHNJ

ABHNJ addressed IPRO's Calendar Year 2019 QTR recommendations as follows:

- *ABHNJ should continue with the project addressing disparities in health care for Hispanic members and should monitor and evaluate progress as data becomes available.*

The Health Plan has implemented the Health Disparities project using the IPRO PIP template to assure a consistent approach to performance improvement, and a way to monitor and evaluate data as it becomes available. In addition, the creation and utilization of the RACI document ensures monitoring of effective and consistent practice.
Based on the latest completion of the disparities project Aetna Better Health of New Jersey demonstrated year over year improvement on all indicators and will continue to monitor data quarterly.

- *The Plan should continue to recruit dental providers and contract with hospitals to improve access to care in deficient counties.*

DentaQuest network was deemed inadequate, ABHNJ reviewed Liberty Dental's network which deemed adequate as a statewide provider. As a result, ABHNJ transitioned to Liberty Dental effective 5/1/2020 as our new dental vendor. Liberty Dental has a statewide compliant network.

ABHNJ and Liberty Dental met weekly for Lead Team meetings from 1/13/19 – 4/27/20. Also held command center meetings (post go-live support) from 4/29/20 - 6/10/20 – during this time the meetings went from daily, to every other day, to weekly.

Additionally, ABHNJ and Liberty Dental meet quarterly to review access requirements and all operational aspects to ensure network continued network compliance.

- *The Plan should develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.*

Aetna Better Health of New Jersey ensures applicable PM Documentation is submitted correctly by utilizing the state's electronic templates for PM's. Every Fiscal year, the Plan receives the State templates for all the MLTSS performance measures and based on IPRO approved source code, quarterly and annual data reports are generated. Data reports are reviewed for accuracy in ordinance with the Performance Measure specifications. Each Performance Measure Specific State template is updated with verified numbers and percentages. Member level details are analyzed in Dynamo (internal documentation system) to write up discoveries. Discoveries are shared with MLTSS leaders to comprehend actions taken to address any quality issues.

Aetna Better Health of New Jersey ensures applicable PM Documentation is submitted timely Based on State issued due dates by utilizing the internal submission tracker. In addition, ABHNJ uses an internal program, Archer, which provides the owners a 14-day, 7-day and 1-day reminder of a deliverable.

- *The plan should develop and utilize a State-approved private duty nursing (PDN) policy. The Plan should implement a process to ensure PDN services are not terminated without collaborating with the member/guardian, primary care provider (PCP) and PDN agency to ensure the member is receiving appropriate care. The Plan should develop a formal process to monitor and assess PDN cases which includes accurate reports of current PDN status, dates of PDN reviews and results of PDN reviews. The Plan should review contracting for personal care assistance (PCA) service providers to address the PCA access issue, which impacts multiple counties.*

The ABHNJ PDN Policy remains under review by the state, final edits suggestions were completed and submitted on 10/5/20.

PDN reports have been developed for monthly review by the CM and MLTSS teams, this includes a drill down of PDN for DDD and DCP&P Populations, and an aged PDN report so we identify member who may need transition services to MLTSS or the DDDSP Program. The formulation and use of these reports assure that members receiving the services are assessed for appropriate hours and are closely monitored for changing status.

In addition, the Plan improved Care Management workflows to address PDN services termination including communication between PCP, caregiver, PDN agency, and medical director/utilization management. Furthermore, a Transitioning Pediatric Members into Adulthood section was added to the PDN job aid to provide guidance to care management team regarding this process.

The MLTSS department has implemented a process to ensure the members PDN provider and Primary Care Provider (PCP) are informed when PDN services are terminated. In addition to Medical Director review, the MLTSS PDN workflow has been updated to include the following prior to terminating PDN: a face-to-face visit, PDN assessment, options counseling, risk agreement, and notification to the PDN provider and PCP by phone and by mail.

- *The Plan should ensure that all MLTSS member grievances are reviewed and members receive a timely resolution letter. The Plan should ensure that MLTSS provider appeals are resolved in a timely manner.*

Aetna Better Health of New Jersey training materials and documentation provide for MLTSS specific turnaround times for review and resolution. In addition, there are multiple levels of case review. A sample of cases are reviewed bi-weekly for timely receipt and resolution including written notification. Staff and manager are notified immediately if errors are identified. The team meets bi-weekly to review the issues, any trends and to determine if there are trends. Any trends either individual or whole team are addressed through staff counsel or retraining as needed. Additionally we report timely resolution of all cases through health plan leadership and Aetna Medicaid segment leaders. Lastly, we do 2 formal audits per year 1) to ensure data accuracy for timely entry resolution and notification, 2) formal file review of every component of the case for accuracy and timeliness.

- *The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.*

The ICM team initiated a 100% chart audit of all clinical level charts (intensive and supportive: standard) beginning in December 2019. The clinical care managers task the supervisor to audit the chart for all components to ensure all NCQA benchmarks and elements have been met. Care managers are then provided feedback in real time regarding any deficiencies or areas of opportunity. Staff take that feedback and improve their documentation or contact member for more information to fulfill and improve areas of clinical performance to meet and surpass the NCQA benchmarks.

- *The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should ensure they have enough members for the population of their PIPs in order to gather meaningful data.*

ABHNJ has hired a clinical lead to oversee the development, implementation and oversight of the State mandated PIPs. In addition, A full review of all PIP interventions will be completed will be completed on a Quarterly basis and a RACI document was completed to ensure monitoring of effective and consistent practice.

ABHNJ identified that the Disparities project had a low population. As a result, the Plan reassessed the population and expanded the population to include 3 additional counties. The Plan will continue to assess all population sizes for all PIPS to ensure we can gather meaningful data.

- *For the Core Medicaid CM Audit, recommendations for the General Population and DDD Population include the following:*
    - *ABHNJ should continue to ensure timely outreach (within 45 days of enrollment) utilizing a minimum of 2 different methods.*
    - *ABHNJ should continue to ensure that timely and aggressive outreach attempts are made to reach members for completion of the CNA when potential care management needs are identified and to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.*
    - *ABHNJ should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of EPSDT exams for the child population. ABHNJ should ensure dental needs are addressed for the adult population including documentation of the visits.*
    - *ABHNJ should ensure the member's CNA and POC are completed timely.*

Outreach – outreach and I.H.S completion remains a focus, we have met with our vendor, Eliza to assure data reports are accurate and pulling all attempts appropriately and that aggressive outreach is sustained when initial contact is not achieved, this include keeping certain members in the persistent outreach, for continual outreach when contact is not successful (for DCP&P members on monthly basis and DDD on 3 months basis). Furthermore, care management recently started reviewing monthly results from MyActiveHealth, a digital health appraisal tool completed by a member on Aetna Better Health's member portal, and using these reports as referrals to care management. For members with prepaid/set minutes for cell phones, CMs will educate the member on calling through member services (which is a toll-free number) to request to be warn transferred to our CMs line. Alternatively, our CMs can ask members for an alternative phone number/landline number to call and complete the CNA.

Timeliness – ABHNJ has collaborated with our corporate partners developing a timeliness dashboard for POC and Assessment completion, this tool will be utilized by the CM and MLTSS teams to have a proactive line of sight for assessments and POC that are approaching the due dates. This new report will give staff and managers an opportunity to closely monitor timeframes and anticipate CNA and Plan of Care timeliness and avert it from becoming late.

Prevention – Report has been developed that includes all pertinent immunization claims received for DDD and DCP&P members enrolled in the Plan, this report is updated monthly and is utilized by the CM team when opening or reviewing a case. Liberty Dental was added as a vendor in May of 2020, expanding the dental network. Furthermore, workflows were updated to ensure staff review claim database prior to discussing gaps in care with the member, encourage members to obtain preventative, and communicate with providers to obtain immunization records and/or lab results. For the members in persistent outreach (who are not willing to work with Care Management but are state mandated for ICM), staff outreaches providers to collaborate and encourage them to contact members in order to meet any gaps in care.

All CM's and coordinators have access to the NJ Immunization database.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for Assessment category include:
  Group D: The New Jersey Choice Assessment should be completed within 30 days of the referral, and should be submitted to OCCO within five (5) business days of the assessment date.

Group E: The MCO should include the date of the last authorized NJCA by OCCO, and the MCO should ensure a NJCA is completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.

Timeliness – ABHNJ has collaborated with our corporate partners developing a timeliness dashboard for POC and Assessment completion, this tool will be utilized by the CM and MLTSS teams to have a proactive line of sight for assessments and POC that are approaching the due dates. This new report will give staff and managers an opportunity to closely monitor timeframes and anticipate CNA and Plan of Care timeliness and avert it from becoming late.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  For groups C and E: The MCO should ensure that cost-effectiveness evaluations are sufficiently documented and that a pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

MLTSS leadership has collaborated with the MLTSS QM lead and the informatics team to create a new internal audit tool. The MLTSS QM lead will conduct monthly audits and monthly meetings with MLTSS leadership to review and discuss audits results. CM's who score below 90% will be remediated and reevaluated for improvement. The monthly audits and internal collaboration will assist in ensuring CMs are completing cost effectiveness evaluations and initiating the CE IDT Process when applicable.
In addition, the MLTSS dashboard allows leadership to monitor completion of the cost effectiveness evaluation for HCBS members.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Groups C and D: The MCO should ensure an initial POC and back-up-plan is completed, signed and provided to the member/authorized representative within 45 calendar days of enrollment in MLTSS.

  Group E: The MCO should ensure an annual POC and back-up-plan is reviewed and signed within 30 days of the member's anniversary from the date of the initial POC.

MLTSS leadership has collaborated with the MLTSS QM lead and the informatics team to create a new internal audit tool. The MLTSS QM lead will conduct monthly audits and monthly meetings with MLTSS leadership to review and discuss audits results. CM's who score below 90% will be remediated and reevaluated for improvement. The monthly audits and internal collaboration will assist in ensuring CM's are completing the POC and backup plan within 45 days of enrollment and ensure review within 30 days from the initial POC.
Timeliness – MLTSS leadership is able monitor and track the number of POC completed within 45 days, the number of POC outstanding, and the number of POC's not completed within 45 days. This report is shared with the respective CM and scheduled as priority.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Groups C, D and E: The MCO should ensure members had a documented face-to-face visit to review member placement and services during the review period and they were completed within the appropriate timeframes. The MCO should ensure members who were enrolled long enough for a quarterly update and had services that required a back-up plan had their back-up plan reviewed with the member at least on a quarterly basis. The MCO should ensure sufficient documentation of changes from the initial POC, and that POCs are reviewed and/or updated, that the member agrees or disagrees with the POC, and that the member signs and is provided with a copy of the POC at each.

  MLTSS leadership has collaborated with the MLTSS QM lead and the informatics team to create a new internal audit tool. The MLTSS QM lead will conduct monthly audits and monthly meetings with MLTSS leadership to review and discuss audits results. CM's who score below 90% will be remediated and reevaluated for improvement. The monthly audits and internal collaboration will assist in ensuring CM's are meeting all

contractual components, including timeliness for quarterly visits, backup plan and POC reviews, in addition to obtaining a signature and providing a copy of each to the member.

Monitoring – MLTSS leadership is able monitor and track the number of POC completed within 45 days, the number of POC outstanding, and the number of POC's not completed within 45 days. This report is shared with the respective CM and scheduled as priority.

- *For the 2019 MLTSS NF Audit, recommendations include the following:*

  The MCO should ensure the facility POC is on file, and the care manager's review of a facility plan of care is documented.

  The Initial MLTSS POC should be completed within 45 days of MLTSS enrollment and the care manger should certify the agreement/disagreement statement is reviewed and signed by the member/POA.

  ABHNJ should confirm there is documentation of participation in facility IDT meetings, and the onsite review of member's placement and services is timely, and there is documentation of an updated POC for a significant change.

  ABHNJ should ensure there is sufficient communication of PASRR Level I, as applicable prior to a NF/SCNF transfer.

MLTSS leadership has collaborated with the MLTSS QM lead and the informatics team to create a new internal audit tool. The MLTSS QM lead will conduct monthly audits and monthly meetings with MLTSS leadership to review and discuss audits results. CM's who score below 90% will be remediated and reevaluated for improvement. The monthly audits and internal collaboration will assist in ensuring CM's are meeting all contractual components.

MLTSS leadership has updated the face to face documentation templates to guide the CM on essential components such as: Ensuring the NF POC is on file, the CM reviews the NF POC, and schedules NF IDT.

Timeliness – MLTSS leadership is able monitor and track the number of POC completed within 45 days, the number of POC outstanding, and the number of POC's not completed within 45 days. This report is shared with the respective CM and scheduled as priority.

AGNJ

AGNJ addressed IPRO's Calendar Year 2019 QTR recommendations as follows:

- *AGNJ should continue to recruit adult PCPs, pediatric PCPs, and contract with hospitals to improve access to care in the deficient counties.*

Adult and Pediatric PCPs

Morris County

This deficiency was cured in 3Q2019 as Amerigroup was able to secure a contract with Atlantic Health Physician Group, a multispecialty physician group with service locations throughout Morris and some locations in adjacent counties. As of 3Q20 96.0% of members have access to 2 Adult PCPs within 6 miles

Hunterdon County

Amerigroup has not met the access standard for adult PCPs in Hunterdon County. As of the August 2020 NJ FamilyCare Managed Care Report, Amerigroup has 500 members in this County; approximately 63% are adults 21 and older.
Since 2012, Hunterdon Medical Center (HMC) has refused to contract with another Medicaid MCO despite numerous attempts made by Amerigroup to do so. The most recent outreach was in September 2020. HMC is the only hospital in this county and

employs most of the physicians. Because of the Hospital's position, the physicians affiliated with the hospital-affiliated IPA will also not contract with Amerigroup.

Amerigroup was granted a waiver from the current facility and primary care network requirements in N.J.A.C. 11:24:6.3(a)1 for Hunterdon County that expired in July 2013. Amerigroup resubmitted this request in October 2017, as well as in September 2020; Amerigroup has not yet received a response to date.

Amerigroup has the ability to utilize an authorization and single case agreement (SCA) process and will coordinate transportation through LogistiCare should any members require out-of-network PCP services. Amerigroup monitors single case agreement requests and there were no requests for out-of-network PCP care for members in this County in 2019 and to date.

Warren County
Amerigroup has not met the standard for pediatric PCPs in Warren County. As of the August 2020 NJ FamilyCare Managed Care Report, Amerigroup has 819 members in this County, approximately 35% are children under age 21.
In September 2020 Amerigroup requested a waiver from the current facility and primary care network requirements in N.J.A.C. 11:24:6.3(a)1 for Warren County.

Amerigroup has attempted to cure deficiencies within Warren County in the geographic areas of Phillipsburg 08865, Columbia 07832, and Blairstown 07825 but these efforts have not been successful. Through these efforts Amerigroup has learned that the St. Luke's hospital system owns the vast majority of PCP practices in these areas. Despite numerous outreach attempts, the St. Luke's Hospital-Warren Campus has not committed to contracting. The most recent outreach by Amerigroup was in December 2019.

While Amerigroup continues to make the best efforts to cure these deficiencies, the single case agreement (SCA) process is utilized should any members require services and need transportation. LogistiCare is available for members that require transportation. Amerigroup monitors single case agreement requests and there have been no requests for out-of-network PCP care for members in this County in 2019 to date.

Hospitals
Amerigroup is in negotiation with the Hackensack Meridian Health system although it is unclear if the parties will be able to agree on a system wide contract at this time. Additionally, the Plan has continually attempted to engage with Hunterdon Medical Center for several years despite past refusals by this hospital to contract with another Medicaid MCO. St. Luke's Warren Hospital, despite continual outreach, has also refused to engage substantively in contract discussions.
Amerigroup has requested participation of St. Luke's Warren Hospital numerous times over the past few year to various contacts there, most recently in May of 2020; facility has failed to reply but outreach will continue. Outreached to Hunterdon Medical Center to request participation in April 2019, hospital once again refused to contract with another Medicaid MCO and advised Amerigroup to call back in one year. Calls to facility in August 2020 have not been returned. Waiver for Hunterdon County has been requested as previously noted.

- *The Plan should continue to expand the MLTSS network to include at least two providers in social adult day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.*

Amerigroup continues to follow the Any Willing Provider (AWP) guidance and negotiates Single Case Agreements (SCAs) as necessary to ensure members receive needed services including transportation to providers as applicable. Recruitment for MLTSS services is ongoing and targeted recruitment is conducted based on deficiencies by county. Amerigroup is seeking to partner with specific providers/provider types in an effort to improve quality and the health plan anticipates this will increase in-network participation as well.

Amerigroup has not been able to identify a provider in Salem County that offers social day care services. Amerigroup currently has a contract with Caring Inc. in adjacent Cumberland County and transportation if required would be arranged at no cost to the member. Single Case Agreements (SCAs) would also be utilized if member requires services at a non-participating provider.

- *The Plan should continue to focus on improving after-hours communication for adult and pediatric PCPs.*

To ensure compliance with State regulations, Amerigroup conducts an annual After Hours audit.
Overall compliance for random sample was 75%, a decrease of 5% from 2019, for the 2020 After Hours survey, administered August 10-25, 2020. For resurveyed providers, this was 64% (no change over 2019).
Amerigroup requires corrective actions Plans from all noncompliant providers. Amerigroup samples corrective action plans to confirm compliance prior to the following year's survey as all non-compliant providers are to be surveyed again the following year. Amerigroup also conducts provider educational meetings to review provider deficiencies and to support them with meeting the goals of their submitted CAP.

Amerigroup has targeted efforts for improving compliance with providers that have answering machines, rather than answering services, to ensure that members have access to reach the on-call provider directly after hours. This is accomplished by conducting meetings to educate providers about and reinforce all access standards while still requiring formal CAPs.

- *The Plan should continue to focus on improving appointment availability for adult PCPs, specialists and behavioral health providers).*

To ensure compliance with State regulations, Amerigroup conducts an annual Appointment Availability audit. The 2020 survey was administered August 10-25, 2020.

Overall compliance for random sample was 91%, a decrease from 95% in 2019. Overall compliance rate for PCPs was 94%, for Pediatrics it was 98%, for high volume OBGYNs it was 88%, for high impact Oncologists it was 84%, and for Other Specialists it was 83%. Behavioral health was 84% for prescribers and 89% for non-prescribers. Re-surveyed provider overall compliance was 85%.

Amerigroup has targeted efforts on improving compliance with the 24 hour urgent care appointment access requirement through educational meetings with providers. The Plan has found that Specialists and Behavioral Health providers are the most challenged by this requirement. For Specialists, many feel that their specialty would not provide urgent care services. Additionally, there is limited availability of urgent appointments within 24 hours of request for specialists. For Behavioral Health, due to the nature of this specialty having longer appointments of 45-60 minutes each, availability of open appointments within 24 hours of request is difficulty to meet.

- *The Plan should develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.*

AGP implemented a semiannual focused cross departmental meeting to review all NJ product codes and performance measure documentation on 5/6/20 and had a follow up meeting on 8/21/20. The group determined that these meetings should be held in July and October of every year to better align with HEDIS/NJ PM deliverable milestones. In addition to these semiannual meetings, AGP data teams met to review end to end HEDIS reporting and quality review processes on 5/8/20. Additional opportunities to improve the quality of submissions will be discussed at semiannual cross departmental meetings in 2021, and will be a standing agenda item.

- *The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.*

AGP continues to monitor its clinical performance against the NCQA 50th percentile on a monthly basis through benchmark reporting, and maintains an intervention work plan which is monitored and updated throughout the year. Clinical performance is evaluated annually and reported through the QM Program Evaluation.

- *The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should review*

Interventions and ITMs and ensure data is being collected appropriately and the Plan should also follow appropriate timelines throughout the PIPs.

AGP continues PIP specific workgroup meetings to ensure ongoing engagement and timely interventions across key departments. Additionally, meeting minutes and follow-up items are circulated after each workgroup meeting to ensure timely implementation and reporting. PIP discussions are a standing agenda item in LTSS/QM Leadership meetings. Dedicated staff have been identified and assigned:

1) AGP continues to have a dedicated nurse resource for LTSS PIPs
2) A dedicated physician has been assigned to non-LTSS and LTSS PIPs to support provider-facing activities
3) A dedicated staff lead within each operational team has been assigned to work with the applicable QM PIP lead. AGP continues to maintain and track ITMs and reporting needs on the PIP monitoring work plan.
AGP will continue the interventions in 2021 and monitor for additional opportunities for further improvement.

- *The Plan should implement a process to ensure that all Core Medicaid member appeals resolution letters are sent out in a timely manner.*

11/12/2019 a Staff in-service was conducted. Staff were provided a comprehensive overview of the appeals workflow and requirements for compliance. Ongoing bi-weekly team meetings with staff to review appeal performance, workflow, and requirement for compliance are in place.

Grievance and Appeal (G&A) team was re-educated regarding contractual obligations for appeal turnaround times. The expectation has been reinforced that an appeal is not completed until the NOA (Notice of Action) has been generated, reviewed and mailed. Additionally, the expectation for the Medical Directors is that their decision is rendered within the timeframe to ensure that finalization of the determination can be completed within 30 calendar days for standard and 72 hours for expedited.

G&A manager monitors workbaskets frequently to ensure cases are timely. On a weekly basis, the Regional G&A Dashboard is reviewed to identify any cases at 26-30 & 21-25 days aging in the market. Nurses who have these case assigned to them are alerted and advised of the need to process and resolve them appropriately. Compliance is monitored through monthly audits. Any TAT reporting below 100% results in a failure. If failure is due to systemic and consistent errors (i.e. late routing of appeals) the appropriate area escalation will occur. If related to internal G&A mishandling of appeal the associate will be re-educated with continued monitoring for compliance and further coaching as needed.

Cross training has taken place to ensure there is adequate staffing at all times to complete appeals timely.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*

  Recommendations for the Member Outreach category include:
  Group D: The MCO should ensure the member file had a documented date of Outreach to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive POC within five (5) business days from the effective date of MLTSS enrollment.

Amerigroup has modified the initial outreach process to target new member outreach to be completed within 5 business days of enrollment. The task is assigned to a medical management specialist (MMS) supporting the field Care Management team to introduce the program, schedule a visit for the purpose of a care plan and gather any pertinent information on behalf of the Care Manager. The MMS also provides a first layer of support for members such as finding a PCP or specialist, sharing the primary Care Manager contact information, etc. Effective June 2020, Amerigroup has created a daily tracking report shared with the MLTSS management team with a status on all initial outreaches for members new to MLTSS. A risk summary report is shared with the management team to identify cases at risk for noncompliance. Amerigroup identified an opportunity to improve the process of loading FIDE-SNP members enrolling into MLTSS. Current process resulted in delays in loading program enrollment information resulting in potentially a

delayed MLTSS outreach. Process improvements have been implemented to update enrollment timely (upon receipt of 834 enrollment file) allowing MLTSS to meet initial outreach compliance. In addition to the daily tracking report, Amerigroup's Compliance Manager is dedicated to daily oversight and escalated notifications for cases at risk.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*

  Recommendations for the Face-to-face Visits category include:
  Groups C and D: The MCO should ensure the Member has a completed and signed interim POC. The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option.

  Group E: The MCO should ensure the Member has a completed and revised POC. The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option.

  Groups C, D and E: The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

  The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

Amerigroup self-identified the opportunity to monitor timeliness, thorough completion and improve the capturing of signatures on MLTSS assessments/documents. Previous clinical platform did not successfully connect member signature to assessment when pulling documents for EQRO audit evidence. With the implementation of a new clinical platform titled Healthy Innovations Platform (HIP) in January 2020, Amerigroup has built functionality to export assessment with signature. This functionality has been applied to State required forms such as Interim Plan of Care (IPOC), Plan of Care (POC), Risk agreement and back-up plan. Amerigroup tracks compliance of the participant direction application packages on an internal tracking tool to trend areas of noncompliance. Effective Q4 2020 (SFY2021 Q2), Amerigroup has a dedicated resource to report and trend compliance using the data housed on the internal tracking site. Using these reports, Amerigroup will monitor timeliness and build appropriate interventions to improve compliance.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*

  Recommendations for the Ongoing Care Management category include:
  Groups C, D and E: The MCO should ensure the Member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes.

  Group E: The MCO should ensure the Member has a completed and revised POC. The MCO should ensure members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan had their Back-up Plan reviewed with the member at least on a quarterly basis.

Amerigroup identified the opportunity for improved monitoring of visit timeliness in March 2020. Reporting enhancements have been made to capture membership compliance with visits and is shared with the management team daily. Weekly management meetings cover areas of noncompliance, trends identified, and interventions to implement. A daily risk email is shared by the Clinical Compliance Manager to alert the management team and clinical director on current compliance. Reports include plan of care (POC) timeliness as well. Monthly reporting has also been built effective May 2020 to monitor visit compliance in the previous month and captures completion of all assessments during that visit, including the back-up plan. Amerigroup has included the above recommendations in chart audits and will trend results.

- *Recommendations for the 2019 MLTSS NF audit include the following:*

  The MCO should ensure the facility POC is on file, and the care manager's review of a facility POC is documented.

  The MLTSS care manager should confirm there is documentation of participation in facility IDT meetings, the NJCA should be completed annually for members newly enrolled in managed care, and ensure the onsite review of member's placement and services is timely.

  AGNJ should ensure the Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF.

  AGNJ should ensure that there is sufficient communication of PASRR Level I and Level II, and that there is sufficient coordination with DDD/DMAHS for specialized services setting.

Amerigroup has updated and retrained staff on care management documentation guidelines to capture the Care Manager's review of the facility POC, participation in facility IDT meetings, and the review or completion of the annual NJCA. Amerigroup continues to maintain specialized Care Managers dedicated to facility care management. Two dedicated Clinical Managers oversee these teams and monitor compliance via reporting and auditing for facility specific care management elements (i.e. compliance monitoring includes review of participation in facility IDT meetings, completion of or confirmed PASRR level I/II and sufficient coordination with DDD/DMAHS for specialized services). Amerigroup has also incorporated facility specific care management requirements in all new-hire training. Associates demonstrating noncompliance with these elements as a result of audits receive 1:1 performance coaching.

HNJH

HNJH addressed IPRO's Calendar Year 2019 QTR recommendations as follows:

- *HNJH should continue to negotiate a contract with dental providers to improve access to care in the deficient counties.*

HNJH Dental Operations continues to collaborate with our dental vendor, Skygen, to identify prospective providers. Once a provider is identified, recruitment efforts begin to include negotiating a fee schedule and credentialing. Our Dental Director is involved in all aspects of the process.

Our current process consists of the following:
1. Outreaching to our large provider groups that may have additional providers joining the practice willing to participate.
2. Review "4 Plus County" network roster to confirm if any providers can be moved to the deficient county.
We are currently negotiating with two providers' offices and will provide an update on gap closure upon completion.

- *The Plan should continue to expand the MLTSS network to include at least two providers in every county for adult social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.*

Horizon is in the process of recruiting social adult day care centers to the MLTSS network. However, Horizon NJ Health is experiencing the following barriers to closing these gaps:

Outreach has been made to the Division of Aging in each county to obtain a list of social adult day care centers. When contacted, some centers respond that they are a senior citizen center and cannot serve as a social adult day care center because it would be a conflict of business interest.

Some social adult day care centers have been legally advised that they cannot coexist in the same space with an adult medical day care center. Also, some social adult day care centers are listed on the Internet as providing both medical

and social day care. When contacted, these centers state they only offer adult medical daycare services (i.e. Careway Medical and Social Day Care Center).

Social adult day care centers are sometimes nonresponsive to outreach efforts. Outreach efforts include calling centers, leaving voicemail messages, and sending emails to the center administrators.
During the credentialing process, extensive follow up is sometimes needed to obtain required documentation. This can delay the credentialing process by several months.

As a result of these barriers, recruiting efforts include encouraging adult medical day care centers to diversify their business portfolio. This education has begun with providers such as Cedar Knolls in Morris County, who only offers adult medical day care services at this time. Facilities like Cedar Knolls are beginning to understand that business diversity is needed to expand the services they provide so they can stay in business.

- *The Plan should ensure that MLTSS member grievances resolution letters are sent to members in a timely manner.*

To ensure all MLTSS member grievances are resolved with timely resolution letters, a daily report was created and distributed to the MLTSS Case Management Team. The report provides advance notice of grievances affecting their assigned members. Workflows have been updated and streamlined to identify the support teams needed for specific issues. Daily inventory meetings are held with the staff to ensure cases are resolved timely and issues needing management support are escalated appropriately. Lastly, our quality review process prior to closure of a grievance ensures that resolution letters are completed and attached to each case for proper documentation.

- *The Plan should develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.*

In response to NJ State observations and recommendations, Horizon has created a process document that details the steps that should be taken to ensure proper NJ State submission. In addition, with the new HEDIS vendor, Inovalon, Horizon was able to create, for measurement year 2019, a reporting population that was all inclusive of Medicaid, DSNP and Dental only members. This allowed the Member Level Files (MLF) to include both FIDE SNP and Medicaid members in each file they were required to be submitted. It also allowed FIDE SNP, Medicaid and Dental Only members to be included in the ADV measure MLF. This will be the process moving forward allowing for accurate and timely submission of performance measures.

- *The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.*

To address the areas where clinical performance was subpar in comparison to the NCQA benchmarks, Horizon focuses on HEDIS performance improvement to achieve NCQA HEDIS 50th percentile or higher for all contract performance measures.

Horizon strives to achieve the goal of 50th percentile or higher, by conducting strict measure review of performance rating and conducting a barrier analysis. Subsequently, an annual HEDIS Work Plan is composed of strategic interventions developed per measure to overcome the organizational and/or population barriers. Upon implementation, the outcomes are monitored, tracked, and/or adjusted as needed to better address the needs of our population, in efforts to ultimately increase the probability of favorable health outcomes

- *For Core Medicaid/MLTSS PIPs, the Plan should continue to implement on-going interventions that track the population in their PIPs.*

Horizon will continue to implement on-going interventions that track the populations' specific to each of the PIPs in place. The Quality Management (QM) department has individual workflows, training modules, data sources, data analytics, findings, year-over-year results and milestones completed for each active PIP. There is also training around

data analysis and lean six sigma improvement methodologies that has been incorporated into the QM team managing the PIPs. This training includes modules relating to identification and tracking of study populations, presentation of data in a consistent manner over time, presentation of study indicator metrics, analysis of ongoing tracking metrics that are designed to evaluate interventions and overall analysis of study results.

The QM department continues to report PIP progress to the Quality Improvement Committee (QIC) on a quarterly basis which includes all relevant documents and a list of deliverables that capture current, ongoing and future responsibilities. This is done in addition to updating the PIP activities in the QIC work plan. Reporting to QIC ensures the PIP's maintain interdepartmental collaboration.

Upon each IPRO PIP review, there is a table of deliverables, which includes all feedback from IPRO relating to the PIP that should be incorporated into the next update. This process has shown to improve the reporting of the PIPs, as the feedback from the August 2019 submission included all active PIPs in the 'met' category, scoring above 85%.

- *For the 2019 Core Medicaid CM Audit, recommendations for the General Population include the following:*

    - *HNJH should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled members. HNJH should also utilize ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members demonstrating potential care management needs.*

    - *HNJH should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources. Outreach attempts should include various types of methods, such as telephonic, written correspondence, provider contact, external agency contact, home visits, etc. HNJH should continue to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.*

    - *HNJH should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of EPSDT exams for the child population. HNJH should ensure that dental needs for the child and adult are addressed for all members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of preventative and dental services and to educate members of the need/benefit of such services.*

HNJH continues to outreach to members within 30 days of enrollment to welcome members to the Plan and complete the Initial Health Survey. We follow internal protocol for follow up within 45 days of enrollment to include additional outreach calls and sending letters to members who we are unable to reach. The letter asks members to return our phone call.

HNJH has enhanced the case management dashboard in 2020 to allow for tracking outreach timeliness for CNA completion within 30 days. Horizon developed an algorithm to enable early identification of members with potential care management needs for prioritization of outreach. Preventative training was developed for clinical and non-clinical staff "Adult and Pediatric Health Maintenance" with planned roll out in Oct 2020.

HNJH continues to address immunizations for adults/children, dental care for children and EPSDT exams for children by doing the following:
1. Monthly educational/reminder IVR call outreach campaign was implemented that targets members ages 15 months old and who are falling behind on immunization schedule per the recommended CDC immunization schedule. Barrier education is provided on the following: nervousness, time, cost, does not need, and transportation-LogistiCare. Date implemented: September, 2020.

2. Happy Birthday Cards are mailed monthly to continuously enrolled members turning 1 year old. Happy Birthday Card is sent to wish the member a happy birthday and includes important health reminders for babies at 1 year old. Reminders include the following: wellness checkup, immunization, first lead screening, and dental. Date implemented: August, 2019.
3. Annual reminders of adult and pediatric immunizations and lead risks and screening are included in member newsletters.

In addition to the recurring interventions above, additional ad hoc interventions are implemented to close gaps in care:
1. Member's turning two years old in December 2019, and who have not completed the combo 10 series of shots were sent a reminder postcard for missed immunizations. Date implemented: August, 2019
2. Horizon has partnered with Ocean Health Initiatives (OHI) provider group to catch up members on missed services/screenings. Horizon's Quality Outreach Coordinators will outreach OHI/Horizon members to help with scheduling appointments for OHI on the spot. Scheduling is done for members who are due for the following services/screenings: lead screening, immunization and or wellness checkup. The outreach call will be part educational and part scheduling for services/screenings. This approach may be beneficial for members who need both the education and help with scheduling an appointment. Additionally, during the call, Horizon will screen for barriers getting in the way of care and help to resolve them. Date implemented: September, 2020.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Face-to-face Visits category include:
  Groups C and D: The MCO should ensure the Care, and the member received option counselling, incorporating a discussion of the participant direction program. The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

To ensure that Options Counseling incorporates the discussion of participation direction, the updated version of the Interim Plan of Care, (post a system enhancement), became effective May 2019 to include a detailed section regarding both PPP and PACE. This has helped Care Managers document the inclusion of these programs among all appropriate alternatives discussed when providing Options Counseling.

Ongoing Quarterly audits are conducted by MLTSS Care Management Supervisors for evidence that members are provided Options Counseling. Additionally, both the MLTSS Options Counseling Workflow and the Cost Effectiveness Analysis Workflow were reviewed, updated and redistributed to care management teams in February 2020.

Care Management continues to ensure that cost-effectiveness evaluations are completed and sufficiently documented. Monthly aggregate reporting continues to review Cost Effective Analysis and is sent to each applicable MLTSS Care Management Regional Manager for review. These spreadsheet reports show an individual listing of member CEAs in the region and includes a brief summary of IDT-related findings to be verified by the applicable Care Manager, for both Annual Cost Exception IDT cases as well as Renewal 85% cases that need review. CM Staff has been advised that the new State cost caps have been released, effective 7/1/2020, and are to be used while reviewing annual service costs.

The MLTSS IDT Workflow was reviewed, updated and redistributed to care management teams in March 2020. Training on the IDT process was conducted by the IDT Team for all Care Management Supervisors in June 2019 and a high-level orientation on the IDT process was created and shared with the HNJH Training Dept. to use with newly hired MLTSS Care Managers to support cost-effectiveness evaluations being completed and sufficiently documented and IDT identified and referred timely.

** COVID-19 Impacts: On March 12, 2020, the NJ State Department of Human Services restricted nonessential visitations by MCO staff into Medicaid beneficiaries' homes, in order to protect their health and well-being. This included the suspension of in-home visits by MLTSS Care Managers for the purposes of conducting Face-to-Face meetings and in-person Assessments of all current and newly identified members. The suspension of in-person encounters with the MLTSS population remains in effect and this continues to impact several aspects of the program operation, however, in-

lieu of those Face-to-Face opportunities, operational processes and procedures continue to be developed, offered, and are evolving, with virtual and remote options that are telephonic and video-based, to continue to meet the needs of the MLTSS membership, including through the provision of Options Counseling.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*

  Recommendations for the Ongoing Care Management category include:
  Groups C, D and E: The MCO should ensure the member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes. The MCO should ensure there is documentation of a face-to-face visit by a care manager within ten business days of a documented date of discharge from an institutional facility to a HCBS setting.

The Compliance Dashboard Report continues to be run monthly for MLTSS Care Management Regional Manager Review. This report is updated with any necessary operational enhancements needed on an ongoing basis.

The Monthly Post Hospital Report Workflow, the Post Facility Visit Workflow, and the Post Facility 30-Day Pledge Workflow were all reviewed, updated and redistributed to care management staff on October 1, 2020 as well.

In December 2019, an enhancement request was made to the previously used In-Patient Stays Monthly report so that Care Management staff would start receiving Weekly alerts to facility discharge dates and when the post 10 day visit is to occur for each case. Currently, on an on-going basis, MLTSS CM Supervisors receive daily alerts via email, regarding facility admission/discharge dates, so that appropriate follow-up by CM staff is made on a case-by-case basis.

Oversight continues to be conducted by the MLTSS Regional Managers and CM supervisors daily by utilizing the MLTSS Dashboard. When warranted, based on report findings, the Care Management Remediation Workflow is followed which includes investigation and disciplinary action, if applicable.

**COVID-19: Despite the State's suspension of in-person assessments and face-to-face meetings, HNJH Care Management continues to ensure regular communications with MLTSS members to review member placement and services during these unprecedented times. Ongoing outreaches by MLTSS Care Managers are made telephonically not only to members, but also to caregivers and service providers. All outreaches are documented in the electronic medical management system.

A Pandemic Care Management Operational Workflow was created and is updated regularly to reflect State-issued guidance on care management expectations. Additionally, the Face to Face Operational Workflow has continually been reviewed, updated and redistributed (most recently on October, 1, 2020) to provide clarification to care management staff on an ongoing basis.

- *Recommendations for the 2019 MLTSS NF audit include the following:*

  NJH should ensure the facility POC is on file, and the care manager's review of a facility POC is documented. HNJH should confirm onsite review of member placement and services is timely, and that members are trained on identification and reporting of critical incidents.

MLTSS Care Management Supervisors continue to monitor the Tableau Dashboard daily to identify case timeliness issues and for identification and follow-up regarding gaps in receipt of Facility Care Plans. Monthly Nursing Facility Compliance Dashboard Reports continue to be utilized for care management staff performance monitoring.

Ongoing MLTSS Care Manager Supervisor audits review a sample of MLTSS member plans of care for review of the facility's care plan. Those monthly chart reviews are also conducted for evidence that the MLTSS Member Handbook was reviewed with members and that both the Service Plan of Care and the Rights & Responsibilities Sign-Off Sheet is

completed as appropriate. This includes indication of member education on how to report critical incidents and suspected abuse, neglect or exploitation.

**COVID-19 Impact: Despite the State's suspension of in-person assessments and face-to-face meetings, HNJH Care Management continues to ensure regular communications with MLTSS members in nursing facilities to review member placement and services during these unprecedented times. Ongoing outreaches by MLTSS Care Managers are made telephonically not only to members, but also to caregivers, and the nursing facility staff. Some nursing facilities were delayed in sending HNJH copies of member facility care plans, due to COVID-19 impacts, but periodic contacts are made by care managers to follow-up as needed.

UHCCP

UHCCP addressed IPRO's Calendar Year 2019 QTR recommendations as follows:

- *UHCCP should continue to recruit adult PCP, pediatric specialists and contract with hospitals to improve access to care in the deficient counties. Where no specialists are available in these counties, the MCO should delineate how specialty care for children in these counties is provided.*

UHCCP currently meets the requirement for PCP network adequacy. We have also outreached to pediatric specialists for possible recruitment and have provided a summary of our outreach efforts to these physicians. If no other providers exist in the area to contract with, we have provided evidence of that research. We will add the following language to our NM-106 Network Adequacy policy "Where there are no providers available in counties with deficiencies, UHCCP can assist the provider or member with obtaining prior authorization so that a single case agreement (SCA) and/or transportation can be coordinated for the member if needed."

- *The Plan should work with the obstetric network to ensure adequate access to prenatal care. Providers not meeting the standard should be requested to submit a corrective action plan (CAP) and should be re-evaluated. The Plan should also address the deficiency with regard to emergency appointments with specialists.*

UHCCP currently educates non-compliant obstetric and specialist network providers of the adequate appointment availability timeframe via mailed letter after it is determined that the appointment timeframe that they provided to the third-party surveyor is deemed non-compliant. After an initial letter is mailed, a follow-up call is made again by the third-party surveyor to see if the provider has corrected their non-compliance. We make outreach up to 3 times by third-party surveyor phone and letter for each failed appointment timeframe response. We will also include emailing providers with a read receipt and continuing to make follow-up calls to educate providers.

Additionally, we have not reported the outcome of these additional outreach efforts made by the third-party vendor, and we have noticed providers' appointment availability has improved after these additional outreach attempts after the notice of non-compliance and State requirements were mailed, thus curing the provider's deficiency/non-compliance. Moving forward, we will include these findings in the Access & Availability reporting to demonstrate which providers have improved and are now considered compliant.

- *The Plan should continue to expand the MLTSS network to include at least two providers in every county for and assisted living in Hudson County. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.*

UHCCP continues to make regular outreach efforts to recruit MLTSS providers in areas that are deficient. Based on the last CAP finding, we have accelerated these outreach attempts to weekly. We will also document the reason why the provider who may be able to fill the gap in access is unable to join the network (did not complete credentialing process, unable to reach, etc.) and present those outreach efforts in the regular quarterly deficiency reporting.

- *The Plan should ensure that Core Medicaid member grievances are addressed with correct resolution letters sent to members as per contract requirement. The Plan should ensure that Core Medicaid provider grievances are*

addressed in a timely manner as per contract requirements. The Plan should ensure that MLTSS member grievances are addressed with correct resolution letters sent to members. The Plan should ensure that MLTSS authorizations are addressed in a timely manner as per contract requirement.

Operating procedures were reviewed to ensure accurate direction is being provided in the documentation regarding Medicaid and MLTSS Member Grievance letter content. Staff training was conducted which covered appropriate issue routing, letter content and QOC/QOS differentiation review. A review of the routing, review and letter process was conducted with the MLTSS QOC staff to ensure future letter accuracy. A daily inventory review is conducted to ensure cases are being routed to the appropriate team timely for processing. A quarterly review of the process is conducted to ensure compliance to the contract requirements including, but not limited to the resolution letter and timeliness.

UHCCP has updated process documentation to ensure alignment with contractual requirement and current processes for provider grievances. All staff who contribute to the process were educated on the turnaround time expectations and requirements. An emphasis has been placed on full resolution, including claims reprocessing (if applicable) within the established turnaround times and communication with providers. Provider grievances are triaged within 24 hours of receipt from compliance or by 5 p.m. the next business day. Daily reports are shared by the compliance team of all upcoming deliverables due within the next 7 days, including provider grievances received via DMAHS and DOBI. The Accountable Owner (AO) and Subject Matter Expert (SME) review the list daily to ensure all upcoming due dates are met. A review of quarterly Table 3C report is completed to ensure compliance with TAT requirements. A weekly touch base is held between AO and SME to ensure provider grievances are triaged timely.

Reporting on authorization is available for NF authorizations via the BCRT report done weekly. Authorizations are submitted internally for NF/SCNF Custodial Expedited Authorizations within 3 business days.

All authorizations provided by OCCO upon NJ Choice Assessment review are documented in both activities and assignments reported in the Activity Tracker Report.

- *The Plan should develop a mechanism to track, monitor and show evidence of enrollee's receiving PDN services and status of services. Reporting from this tracking system should accurately reflect dates of changes or of termination of PDN services, dates of evaluations and reasons for changes to level of services or termination of services. The Plan should develop and implement a mechanism for identifying members who are turning 21 and should ensure that adequate transition planning occurs for these members. The Plan should provide training to all care management (CM) staff to ensure that they are equipped to navigate the systems so that they can track and document services provided to members.*

    - The Plan has developed a PDN tracking report to monitor and show PDN services enrollees are receiving. the Tracker will capture the following information: Member's name, Medicaid ID, Assessment Date, UM review Date, Current PDN hours, status of services, dates of changes, termination of PDN services, Reason for termination, service increase/decrease with dates, Services on Hold with reasons and dates. dates of any service changes with reason.

    - The report is scheduled to run in November 2020 and will capture all the information for UHC members receiving PDN services.

    - We will run the reports daily and weekly and will send to it to you once available in November2020. The report will be run by operations and care management team and will be reviewed by PDN manager, PDN Care Manager and PDN Clinical Associate Coordinator.

    - The Plan has developed a process that is used to identify members who are turning 21, to ensure adequate transition planning for those members.

The Plan will conduct a comprehensive training for all the care management and utilization management staff on all the changes and on how to track and document services provided to members and changes in services/status. This training will take place on 10/28/2020, a roster and training documents can be provided post training. Once training is completed, we will send you the roster and completed training documents.

- *The Plan should ensure that all delegates review quality metrics, including a review of complaints/quality issues, at the time of recredentialing, and that this is documented in the Core Medicaid recredentialing file.*

UHCCP We will continue to monitor all credentialing delegates for the activities they are responsible for performing on our behalf and as described in the UnitedHealthcare Credentialing Plan and State Addendum. The Plan is currently discussing new processes that will ensure that the quality metrics, review of complaints are captured at the time of recredentialing. A new provider recredentialing check list has been created to capture the listed areas for review, this checklist will also be documented in the Core Medicaid recredentialing file. Quality of care issues are captured and is documented in the Core Medicaid recredentialing file.

- *The Plan should ensure dental file review of critical incident events and grievances and that this is documented in the Core Medicaid recredentialing files.*

As per the QM-002 National Credentialing and Recredentialing policy, all dental critical incidents, member complaints and quality of care issues are reviewed and submitted to the credentialing department. Any files that do not meet the threshold of these areas are flagged and submitted for further review by the Quality Management Department and Credentialing Team. This data is also obtained in included with the providers files.

- *The Plan should develop a process for changing a PCP. The Plan should establish clear and consistent guidelines regarding identification of member grievances that underlie requests for PCP changes.*

The Plan developed and implemented a standard process of capturing and tracking all PCP Changes. The member service advocates (MSA) are trained to use appropriate disposition codes to report and identify the reason for a PCP Change. A monthly report is generated for reporting and tracking all PCP changes and the reason for the change.

A specific disposition code “Member Request Dissatisfaction” identifying the PCP change resulting in a grievance was made available effective 7/1/2019. The MSAs would use the disposition code to identify PCP change grievances, then completes a service form to file the grievance. The request is then routed to Appeals & Grievances team for resolution. A quarterly report of all PCP change grievances is being generated for review and monitoring beginning 2020. The report includes the Member ID, Member Name, PCP change request date, PCP Change reason, Grievance Case Id, resolution, Resolution date and Provider details.

- *The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.*

In addition to the annual Work Plan (WP), UHC CP developed a detailed WP for the measures with rates below the NCQA 50th percentile. This WP detailed various interventions and initiatives aimed at improving clinical improvement, including increased provider engagement and education, greater member outreach, and deployment of best practices. Specifically, the Clinical Practice Consultants (CPC) met with Providers to review HEDIS measures, shared documentation tips and recommended billing codes. The Member Engagement team and the Quality Outreach staff messaged members with letters, brochures, and live calls offering direct scheduling and transportation if needed. Shared best practices included ensuring EMR BMI calculation flag is activated, calculating BMI% versus value and documenting result on appropriate graphs, utilizing 90-day refill programs, and scheduling next appointment before completion of current visit. Of the 13 measures with rates below the 50th percentile for 2019, 9 (69%) had improved rates in 2020. Overall, the average increase was per metric was 2.715%.

- *The Plan should continue to strengthen analytic support and address deficiencies in implementation for all Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should continue to utilize strong interventions and ITM's to ensure the Plan is capturing meaningful data.*

The following PIPs were submitted in August/September 2020:
1. The Early Intervention PIP
2. The Adolescent Screening PIP
3. The MLTSS GAP In Care PIP
4. CCIP PIP Hypertension New Proposal
5. Medicaid ER Visit Reduction New Proposal
6. DSNP ER Visit Reduction New Proposal

The MCO has not received the PIPs from the August/ September submissions from IPRO with a scoring YTD.

We have reviewed the auditors' recommendations and requests for clarification for the PIPs prior to the August submission. All issues were corrected, and recommendations were implemented to address the Auditors' concerns/corrections. The PIPs were updated to include any process measures/intervention results and to evaluate the results and value of those interventions. After additional review of the improvements in the process measures and/or the performance indicators, all irrelevant interventions were removed as recommended and additional process measures and interventions were then added. All PIPs were submitted in April and August.

The MLTSS GAP In Care PIP April submission recommendations was reviewed at a meeting with IPRO to ensure an understanding of the issues and recommendations. All issues were corrected, and recommendations were added to the August submission.

Meetings and trainings are held quarterly to ensure that any process measures in place that requires the staff to complete specific tasks are made. They are as follows:

1. Early Intervention: Meetings are held monthly with the member outreach staff and the Lead Case Managers to ensure that communication with these two groups is optimum and data is being tracked. The Early Intervention Testing was temporarily discontinued due to COVID 19 in March 2020 but has resumed. Continuous collaboration with the County Early Intervention Testing Office Team to track the ongoing referrals continues. Monitoring of claims monthly has been implemented to ensure accurate accounting of Early Intervention claims due to previous issues with claims collection.

2. Adolescent screening: Continuous contact with the 3 specific practices occurs quarterly along with a mini audit to determine if progress is being made regarding the screenings. Ongoing meetings with the Member Outreach staff to determine the progress of the Parent Outreach regarding their child's upcoming adolescent visits. The Quality Clinical Nurse Analyst, the Quality Manager and the Medical Director attend the Adolescent Collaborative meetings. The adolescent visits were temporarily disrupted in March 2020 due to COVID 19 but have resumed both in office visits and telehealth visits. The MCO is monitoring the impact on the chart documentation and ongoing discussion with the practices continue.

3. MLTSS GAPs in Care: Continuous monitoring of both the flu/pneumonia rates and the PCA services were implemented 3rd quarter of 2019. The documentation form for Care Managers was reviewed and changes to enhance the improved documentation by the Care Managers were implemented in the 3rd quarter of 2019. The Face to Face meetings with the MLTSS Members and the MLTSS Case Managers were temporarily discontinued due to COVID 19 in March 2020. The Face to Face visits to capture the Flu/Pneumonia information and the PCA services was re-implemented in September 2020 telephonically and will continue until the Face to Face visits resume in person.

4. New PIPs Collaboration with multiple leadership representation was employed to develop the new PIPs which included the national CCIP team, the Chief Medical Officer, the Quality Director, national Basis technical analysts and multiple Health Operations Directors.

These PIPs are reviewed by multiple levels of staff. The PIPs are developed, reviewed and updated for the required timeframe by the following Staff/Leadership: We utilize the following review process for both the April and August submissions. They are as follows:

The Senior Clinical Analysts/ Quality Manager update the PIPs with any necessary information for the appropriate required submission The Quality Manager reviews in collaboration with the Senior Clinical Analysts for any incorrect or missing information and is corrected.

The following leadership then review the documents for any corrections and recommendations. The PIPs are then revised as needed.
1. The Quality Manager
2. The Quality Director
3. The Chief Medical Officer/Medical Directors
4. The National Quality Team

The MCO will continue to strive to improve these PIPs and ensure that the PIPs are clear, and all document information is accurate and relevant to the outcome of the Performance Indicators.

- *For the Core Medicaid CM Audit, recommendations for the General Population include the following: UHCCP should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled members.*

UHC Case Management department outreaches telephonically three times and then sends an UTR letter to newly enrolled members. These are two methods for outreaching to new members. Case Management Policy- PCM3-SNU-P38 Aggressive Outreach, is in place for the CM aggressive outreach policy. UHC adheres to the timeliness outlined in the Case Management Workbook in the NJ State Medicaid Contract. UHC has reporting in place to monitor compliance and this report is reviewed for timeliness (NJ State Mandated Executive Summary). UHC also conducts internal audits on a monthly basis, the tool includes timeliness of assessments.

- *UHCCP should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources. UHCCP should continue to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.*

UHC Case Management department conducts three aggressive outreaches, conducted telephonically, to complete a CNA. Also, an UTR letter is sent to the member if unsuccessful telephonically (outreaches made to PCP, Specialists, pharmacy). UHC has reporting in place to monitor compliance and this report is reviewed for timeliness (NJ State Mandated Executive Summary). The NJ Mandated Executive Summary is utilized to assess compliancy of the CNA. Direction for timely completion of assessment are in our internal Job Aids and Policies and Procedures and reviewed with existing and new staff. UHC also conducts internal audits on a monthly basis, the tool includes timeliness of assessments

- *UHCCP should continue to focus on age-appropriate immunizations for the adult populations enrolled in care management. UHCCP should ensure that dental needs are addressed for all children and adult members enrolled in care management, including documentation of the last visit date. UHCCP should ensure the member's CNA and POC are completed timely.*

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UHC obtains immunization data from the New Jersey Immunization Information System (NJIIS) on a monthly basis which is distributed amongst the care managers for follow up, in addition to attempts to obtain immunization data from member's PCP/Specialist. UHC case managers will document in the Case Management notes and Plan of care in Community Care and ICUE applications. The CM team utilized the Community Care application to assess preventative

care and age appropriate immunizations. Community Care application is used to identify any gaps in care, then addresses as indicated.
UHC will obtain status of dental services by pulling a monthly report of dental claims, in addition coordinating with the child and/or adult dental provider, and continued collaboration with the UHC dental department to ensure all members have a dental home.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Assessment category include:
  Group D: Although not scored, the MCO should complete a screening tool prior to completing a New Jersey Choice Assessment (NJCA) to identify potential MLTSS needs. The New Jersey Choice Assessment should be completed within 30 days of the referral.

The Screen for Community Services (SCS) tool completion process was implemented on 1/1/2020. UHC utilizes the SCS tool to assess individuals who will likely meet the New Jersey Nursing Facility Level of Care designation based on needs for assistance in the community or other care setting. On the Core Medicaid team, the Program Owner Report is used to track SCS tool completion for members and to track timeliness of completion of New Jersey Choice Assessments within 30 days of the referral.
The SCS Job Aid was updated and implemented on 2/18/2020 and staff were re-trained on the process. The most recent SCS training was held for new Care Managers on 10/7/2020.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Member Outreach category include:
  Group D: The MCO should have a process in place to document the date/s of successful and unsuccessful outreaches to schedule a face-to-face visit for the purpose of creating a POC within five (5) business days from the effective date of MLTSS enrollment.

UHC developed a process to document outreach efforts including for those members who were unable to be reached. Outreach calls are conducted within 5 business days from MLTSS enrollment to schedule a face to face assessment to create the Plan of Care in collaboration with the member. The attempts to reach the member are done on 3 consecutive business days at three different times of the day, with one call after normal business hours. All attempts are documented in ICUE Program Level, using the standard activity tracker. If member is not reached after the first attempt, emergency contact on file is attempted. If unable to reach on second attempt, the PCP is outreached, as well as providers if the member is receiving outpatient services, or a facility if receiving inpatient services.

All attempts and follow up research are documented in real time, on the same day. After third and final attempt, an Unable to Reach Letter is mailed to the member. Further follow up is done by the CMA to attempt to outreach member, and to continue to follow up to verify if member has responded to UTR letter within 30 days. The attempts are documented in ICUE.

Training for the Member Outreach process was conducted with staff in April 2020. Staff can monitor those members who are Unable to Reach through the NJ Initial Assessment Monitoring and Adherence Report.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Face-to-face Visits category include:
  Groups C, D and E: The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option. The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

UHC has stopped sending application packages to DMAHS as of December 2018. UHC obtains internal approval and submits a delta file directly to PPL for authorization of approved budget via ICUE within 30 business days of a completed

PPP enrollment application and for COC authorizations for MCO transfers. As of 10/13/2020, the PPP policy has been revised and will be provided to UHC staff in a training as of December 2020.

UHC completes CEA evaluations any time there are new services, at each quarterly face to face visit, and at each NJ Choice Assessment and with any significant change in condition. The process is done using the NJ CEA tool and documenting in the C&S: NJ LTSS On-Site F2F Visit Assessment (Home and Community) at each quarterly face to face visit. It is updated and documented in ICUE via an activity and assignment at the member program level for both the visit and POC completion. The Manager Quality Audit Report ensures proper documentation of the CEA that was noted on the POC. Additional training on the CEA was conducted for all staff on 6/24/2020.

The pre-call is completed prior to the IDT for those 85%-99% of the Cost Threshold and new members within 30 days from the completion of the annual assessment. Documentation is sent to the State one week prior to the call. The MLTSS PDN Manager utilizes the CR5 Report to track all cases that are between 85-99% and 100% and above the Cost Threshold and submitted to the State quarterly. The MLTSS PDN Manager maintains internal report for all IDT and dates completed. Most recent training was completed on 6/23/2020 on the updated CEA.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Initial Plan of Care (Including Back-up Plans) category include:
  Groups C and D: The MCO should ensure a completed and signed initial POC is provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.

  Group E: The MCO should ensure member's annual POC is reviewed within 30 days of the member's anniversary (from the date of the Initial POC).

  Groups C, D and E: The MCO should ensure there is documentation to reflect a member-centric approach, which demonstrates involvement of the member in the development and modification to the agreed-upon goals; this includes that the member and member representative, as applicable, are reflected in the documentation as present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the POC. The MCO should ensure that there is documentation of a completed and signed state mandated Back-up Plan. The MCO should ensure that a signed Risk Management Agreement is documented when the Risk Assessment identifies a positive risk indicator.

Group C and D: United Health Care has a report that captures the timeliness of the Initial Plan of Care completion. This report is used to track compliance with the 45 day from enrollment requirements for the completion of the initial Plan of Care. Currently, the Basis team is modifying this report to include the date that the Initial Plan of Care is mailed to the member. The Care Management Team completes an assignment when letters are mailed to the member. This report will allow the management team to track the number of letters that were mailed within required timeframes and those that weren't. This modification will allow the MLTSS Management Team to track compliance and develop a corrective action plan for those members who have not received Plan of Care letters timely. This report modification is expected to be completed by 1/1/2021.

Group E: The NJ Annual Assessment report ensures that member's Annual Plan of Care is reviewed and updated within 30 days of the Annual Plan of Care. Currently, the Basis team is modifying this report to include the date that the Annual Plan of Care is mailed to the member. The Care Management Team completes an assignment when letters are mailed to the member. This report will allow the management team to track the number of letters that were mailed within required timeframes and those that weren't. This modification will allow the MLTSS Management Team to track compliance and develop a corrective action plan for those members who have not received Annual Plan of Care letters timely. This report modification is expected to be completed by 1/1/2021.

Groups C, D and E: The MLTSS NJCA Audit Tool has been developed to monitor CM documentation to reflect that a member centric approach was completed. This tool will be utilized by the MLTSS Managers to randomly select members

assigned to Care Managers. Care Managers who score below 90% will receive mediation and the tool will be used to identify trends and education opportunities for the MLTSS team. Care Management training in using SMART Goals to create plans of care with the member was conducted in July 2020. Options counseling training was provided on 6/18/2020. The MLTSS Back-up Plan Assessment allows the Care Manager to assess the members choice of who will provide care in the absence of HCBS service provider. The Back-up plan job aid and assessment was revised and implemented on 10/8/2020 to address these occurrences. The Risk Management Agreement is developed with the member to identify any potential risks. The member signs the Risk Management Agreement and is provided with a copy.

- *Recommendations for the 2019 MLTSS NF audit include the following:*
  UHCCP should ensure the facility POC is on file, and the care manager's review of a facility POC is documented.

  Within 45 days of MLTSS enrollment the initial POC should be completed, agreement/disagreement statement is signed, and ensures documentation of written member goals which include all 5 components and confirm the care manager addresses formal and informal services.

  The MLTSS POC should be developed utilizing person-centered principles, and the member and/or representative is included in the development of goals.

  UHCCP should ensure that there is documentation of participation in facility IDT meetings, and the onsite review of member placement and services are timely including documentation of care coordination as applicable, member training on identifying/reporting critical incidents is documented, that there is documentation of an updated POC for a significant change.

  UHCCP should ensure that there is sufficient communication of PASRR Level I and Level II.

UHC CMs receive facility POC to use in conjunction with creating internal POC every 180 days upon outreach to the facility and are saved to ECAA and documented in an activity and assignment. The POC is completed and mailed to member and PCP by the CMA within 45 days of MLTSS enrollment and monitored with an assignment in ICUE. The current IPOC report will allow the management team to track the number of letters that were mailed within required timeframes and those that weren't. This modification will allow the MLTSS Management Team to track compliance and develop a corrective action plan for those members who have not received Plan of Care letters timely. This report modification is expected to be completed by 1/1/2021.

IDT meetings utilizing the IDT Transition Plan Sign in Sheet are completed within 14 calendar days of receipt of notification. The Community Transitional Services checklist documents any services needed for ICHNJ members. The HCBS CM will complete an NJ Choice Assessment for significant change in status and complete and update IPOC upon conclusion of IDT meeting. All actions taken during IDT meeting are documented on the IDT Transition Plan Sign in Sheet and in an activity in ICUE and uploaded to ECAA.

UHC utilizes reports including the NJ Annual Assessment and Annual IDT Adherence to ensure timely IDTs are completed at least annually. UHC is currently writing IDT policy to be completed and disseminated by 1/1/2021. Upon initial and annual outreach of NF members, UHC obtains a Level 1 and/or Level 2 PASRR from the facility via fax. Utilizing the NJ Choice Assessment Narrative Checklist, the PASRR level will be documented in the narrative. Updated Nursing Facility Care Management and Nursing Facility Transition Process Policies and Job Aids were created as of 10/02/2020. Nursing Facility Transition Process was disseminated to all staff in training on 10/15/2020. Nursing Facility Care Management Process to be disseminated and trained to all staff in November 2020. Previous training on POC Completion and Narrative Checklist completed in March and April 2020.

UHC completes audits of NJ Choice Assessments to ensure either PASRR Level I or II are completed and documented for all members residing in a facility. As of January 2021, PASRR Level information will be tracked using the NJCA Audit SharePoint Site.

WCHP

WCHP addressed IPRO's Calendar Year 2019 QTR recommendations as follows:

- *The Plan should ensure that additional adult and pediatric PCPs are included in the new counties to meet the access requirements.*

The Warren County deficiency was monitored by the Network Management Team. Targeted providers that would cure the deficiency were reviewed weekly for recruitment. GeoAccess failed zip codes were identified and targeted providers specific to these zip codes were outreached. In Q2 2019 the GeoAccess for Warren County Adult PCP was at 65.5%. As of Q3 2019 the Plan met adequacy for Adult PCP for Warren County at 100%

Currently, the Plan meets adequacy in all counties.

- *The Plan should develop an action plan to address hospital access for all members and delineate how and where access will be provided for members in counties with inadequate hospital access.*

WellCare will continue to recruit any remaining Hospitals where there is a deficiency, and where needed, WellCare will use its existing contracted Hospitals in adjacent counties and will use Single Case Agreements, as needed.

- *The Plan should continue to expand the MLTSS network to include at least two providers in every county for assisted living and social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.*

Cumberland county: There 3 facilities in the county, WellCare has a signed contract with Spring Oaks. WellCare has reached out and visited Mr. Joseph Dasilva, Executive Director, at Baker Place and Ms. MYERS at Maurice House with no success. WellCare will continue to reach out to Baker Place and Maurice House until they agree to contract. Single Case agreements are available on a case-by-case basis.

Salem County: There are 3 facilities in the county- WellCare continues to reach out to Mr. DANIEL MURRAY administrator at Friends Village At Woodstown, Mr. JOSEPH DETZNER administrator at Lindsay Place, and Ms. SHELLY AYARS administrator at Merion Gardens Assisted Living. Next steps are to do a site visit.

Hudson County: There is one Assisted Living Facility in the county Alaris Health at The Atrium, WellCare has a contract with the provider. Provider ID# 1029714 (true deficiency). WellCare will use providers in bordering counties for additional coverage.

Hunterdon County: There is one Assisted Living Facility in the county; Independence Manor at Hunterdon WellCare has a contract with the provider. Provider ID# 997140 (true deficiency). WellCare will use providers in bordering counties for additional coverage.

Social Adult Day- WellCare currently has contract with 15 Social Adult Day Care Ctr's. We continue to use providers in bordering counties. When there are not enough providers in a specific area to provide adequate, timely access, or in certain cases when certain high-need providers are not willing to contract with us due to rates, unwillingness to serve Medicaid enrollees, or for other reasons, we offer the option of Single Case Agreements. Where possible WellCare will continue outreach and engage providers to closed network gaps.

We are currently working on recruitment of the providers below:

PROVIDER	ADDRESS	COUNTY
Middlesex Social Day	21 Courtland Street, Edison	Middlesex
Evergreen Social Care, LLC	160 Ewingville Rd, Ewing	Mercer
Victorian Garden Adult Day Center	353 Main St, Chatham	Morris

PROVIDER	ADDRESS	COUNTY
Open Arms Adult Day Club	18B Maple Street, Lebanon	Hunterdon
Clarendon Adult Day Center	30-34 Okner Parkway, Livingston	Essex
Generation Station, LLC	545 Beckett Rd, Logan Twp	Gloucester
Silvertime LLC	600 Mule Rd, Toms River	Ocean
Home Sweet Home	860 Route 168, Turnersville	Gloucester
Gift Social Adult Day Center	1150 Delsea Drive, Westville	Gloucester

- *The Plan should continue to focus on improving appointment availability for specialists in urgent care, obstetrics/gynecology (first trimester care and high risk), as well as after-hours availability.*

In August 2019, the Plan hired a new vendor to conduct the A&A surveys (Faneuil). The previous vendor did not survey the needed amount of providers therefore providing misleading results for WellCare. For 2020 the Network Management team implemented an initiative to visit all failed OB-GYN providers in person to re-educate and reinforce Access & Availability standards. Due to COVID-19 some of those interactions became virtual visits. The department outreached all failed providers for education and this was completed on May 15, 2020. Access & Availability access standards for PCP's, Specialists and OB-GYN providers are also in all Provider Newsletters for 2020. Results from our 2020 Access & Availability survey for specialists in urgent care demonstrated improvement to 98.8%, for Obstetrics/Gynecology first trimester improved to 92.6% and high risk also increased to 92.6%. For Obstetrics/Gynecology after-hours availability for return calls improved to 94.4%.

- *The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.*

WCHP conducts quality focused provider education visits to each provider that does not meet the NCQA 50th percentile benchmarks. These visits are focused on coding and claims submission education, the review of gaps in care for their members, provider Toolkits which includes information on all HEDIS measures, best practices and medical record documentation guidelines. Provider Relations and Quality have partnered to coordinate efforts to close care gaps and educate providers on clinical practice guidelines. This interdepartmental (POD) team approach reviews and identifies specific practices/providers with opportunities for improvement of their HEDIS rate. The POD team educates and assists the provider with care gap reports and missed opportunities. The POD team also educates on proper coding to be utilized. The POD team along with the practice/provider review samples of their medical records to ensure they are following medical record guidelines as well as utilizing accurate coding. WCHP also provides a laminated coding sheet with the current codes for the billing staff to ensure claims are processed accurately and timely. This process includes reviewing a sample of medical records to identify coding deficiencies then educating providers. WCHP leadership and Quality staff monitor on a monthly basis POD (Interdisciplinary) progress as well as practice/provider progress. WCHPs Preventive Service Outreach (PSO) program to make outbound calls to non-compliant members notifying of their need for preventive services and assist with setting appointments. To improve quality scores, WCHP also utilizes the Quality Incentive programs.

- *The Plan should continue to strengthen their Performance Indicators and Interventions to address deficiencies in implementation for all Core Medicaid and MLTSS PIPs that were active at the end of the review period.*

WHCP reviews and addresses PIP deficiencies as identified by IPRO. A dedicated Project Manager is assigned to each PIP to coordinate monthly PIP meetings with key stakeholders to discuss PIP progress, including barriers and the need for new and/or modified interventions. A QI Data Analyst routinely attends these monthly meetings. Key QI and Care Management staff attended IPRO's Annual PIP training. Based on IPRO scores of WCHP's PIP submissions in August 2019, the Plan has demonstrated improvement in all three active PIPs and exceeded an overall score of 85% (MET) as follows: MLTSS Gaps in Care (87.5%), Adolescent High Risk Behaviors and Depression (87.5%), and Early Intervention to Prevent Developmental Delays (100%).

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Assessment category include:
  Group E: The MCO should ensure documentation includes the date of the last authorized NJCA by OCCO (either the date of an approval letter or electronic approval). WellCare should ensure the NJCA is completed within 11 to 13 months from the previous NJCA to reassess for clinical eligibility.

WCHP reviews the status of the latest NJCA at the time of enrollment. A request is sent to OCCO within the first week to request any NJCA that are not present. This outreach is documented in each member record and is tracked via the monthly audit process. Any NJCA not received by the time of the initial face-to-face visit will trigger the care manager to conduct to complete a new NJCA. The management team monitors the bi-weekly tracking report to determine the date of the last NJCA in an effort to ensure compliance with re-assessment every 11-13 months. This is also monitored through the monthly CM record audit process. The goal is to minimize the number of members who appear on the monthly DoAS 13 moth report. Staff whose assessments frequently appear (3x) are subject to internal corrective action measures. Audit results as well as findings on the 13-month report are used for ongoing CM education.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Member Outreach category include:
  Group C: The MCO should have a process in place to document the date/s of successful and unsuccessful outreaches to schedule a face-to-face visit for the purpose of developing a POC within five (5) business days from the effective date of MLTSS enrollment.

WCHP reviews the status of the latest NJCA at the time of enrollment. A request is sent to OCCO within the first week to request any NJCA that are not present. This outreach is documented in each member record and is tracked via the monthly audit process. Any NJCA not received by the time of the initial face-to-face visit will trigger the care manager to conduct to complete a new NJCA. The management team monitors the bi-weekly tracking report to determine the date of the last NJCA in an effort to ensure compliance with re-assessment every 11-13 months. This is also monitored through the monthly CM record audit process. The goal is to minimize the number of members who appear on the monthly DoAS 13 moth report. Staff whose assessments frequently appear (3x) are subject to internal corrective action measures. Audit results as well as findings on the 13-month report are used for ongoing CM education.

- *For the 2019 MLTSS HCBS CM audit, recommendations include the following:*
  Recommendations for the Ongoing Care Management category include:
  Groups D and E: The MCO should ensure the member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes. The MCO should ensure members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan had their Back-up Plan reviewed with the member at least on a quarterly basis.

WHCP reviews status of ongoing quarterly visits through individual care conferences using the individual SHS report. The SHS report provides detail on each member including a column specific to last visit date and is sortable to show latest. Monitoring for back-up plan review is completed as part of the monthly record audit. Documentation for back-up plan review is included in the quarterly visit template note. Areas of lower aggregate performance are address in monthly education sessions. Individual performance below 90% is address in individual performance improvement plans.

- *Recommendations for the 2019 MLTSS NF audit include the following:*

WCHP should certify that within 45 days of MLTSS enrollment the initial POC should be completed, agreement/disagreement statement is signed, and ensure documentation of written member goals which include all 5 components and confirm the care manager addresses formal and informal services.

The MLTSS POC should be developed utilizing person-centered principles, and ensure the member and/or representative is included in the development of goals.

WCHP should ensure there is documentation of participation in facility IDT meetings, and the onsite review of member placement and services is timely including documentation of care coordination if applicable. Member training on identifying/reporting critical incidents should be documented.

WCHP should ensure a NJCA is completed at least annually and there is documentation of an updated POC for a significant change in member's condition including the member's signature.

To ensure a member-centric approach demonstrating involvement of the member (whether residing in a NF or an HCBS setting) in the development and modification to the agreed-upon goals (which include that the member and/or member representative is present during the development of his/her goals, options are offered, that there is opportunity to express needs or preferences, and that needs or preferences were acknowledged and addressed in the POC), the following was put in place by the Plan:

Plans of care are reviewed and discussed in 1:1 case conferences between MLTSS managers and care managers and tracked via monthly CM audits to ensure that Plans of Care are developed using "person-centered principles".

The MLTSS Management team requires newly hired care managers to submit 100% of care plans for review at time of completion until their Manager/Supervisor is satisfied with plan of care quality, including that Plans of Care are developed using "person-centered principles".

At least two MLTSS members are discussed at each individual care management team's regular staff meeting, which includes discussing the quality of the plan of care to reinforce best practices in plan of care completion.

Care Plans are reviewed and tracked by a team scorecard that focuses on Plans of Care being developed using person-centered principles. The Clinical Quality management team has taken the lead on this initiative and Care Managers that have Plans of Care not meeting these standards will be re-educated and or have an individual improvement plan developed if indicated.

To ensure that the IDTS have taken place, the management tracks this during 1:1 conferences, monthly CM audits. As in other areas of underperformance, this area can be used as an education topic or as a component for individual performance improvement.

As noted in Recommendation # 7, Presence of the NJCA is also monitored for NF members through the monthly CM record audit process. The goal is to minimize the number of members who appear on the monthly DoAS 13 moth report. Staff whose assessments frequently appear (3x) are subject to internal corrective action measures. Audit results as well as findings on the 13-month report are used for ongoing CM education.

CHAPTER 5 – CONCLUSIONS AND RECOMMENDATIONS

This report has provided an overview of activities and findings for January 2020–December 2020. The following section provides a summary of MCO-specific strengths and opportunities for improvement.

ABHNJ

ABHNJ had an enrollment of 106,834 for Core Medicaid and MLTSS as of December 2020, which represented 6% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

ABHNJ's compliance score for 11 of 13 reviewed standards in the 2020 Annual Assessment of Operations Review was 100%.

The Plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2020 Annual Assessment of Operations Review.

For HEDIS PMs, the Plan exceeded the 75th percentile for the following measures: Comprehensive Diabetes Care (CDC; Medical Attention for Nephropathy), Statin Therapy for Patients with Cardiovascular Disease (SPC; 21-75 years (Male) - Statin Adherence 80%, Total - Statin Adherence 80%), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; Counseling for Nutrition - 3-11 Years, Counseling for Nutrition - 12-17 Years, Counseling for Nutrition – Total, Counseling for Physical Activity - 3-11 Years, Counseling for Physical Activity - 12-17 Years, Counseling for Physical Activity – Total), Antidepressant Medication Management (AMM; Effective Continuation Phase Treatment), Follow-Up After Emergency Department Visit for Mental Illness (FUM; 18-64 years - 30-Day Follow-Up, 18-64 years - 7-Day Follow-Up, Total - 30 Day Follow-Up, Total - 7 Day Follow-Up), and Risk of Continued Opioid Use (COU; 18-64 years - >=15 Days covered, 18-64 years - >=31 Days covered, Total - >=15 Days covered, Total - >=31 Days covered).

In the 2020 Core Medicaid CM audit, ABHNJ scored above the 80% standard for two categories (Outreach and Coordination of Services) for both populations (DDD and DCP&P). ABHNJ scored 100% for Outreach for the DDD population, and 99% for Outreach for the DCP&P population. The Plan scored 100% for Coordination of Services for the DDD population, and 99% for Coordination of Services for the DCP&P population.

In the 2020 MLTSS HCBS CM audit, ABHNJ scored above 90% for MLTSS PM #9 Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary, MLTSS PM #10 Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment, and MLTSS PM #16 Member training on identifying/reporting critical incidents.

Opportunities for Improvement

ABHNJ scored below 85% compliance in 1 of the 13 standards in the 2020 Annual Assessment of Operations Review. ABHNJ scored 79% for Access, which was below the 85% standard.

For HEDIS PMs, the measures that had all or most rates below the NCQA 50th percentile present opportunities for improvement.

Review of the Core Medicaid/MLTSS PIPs identified opportunities to improve oversight of data collection and implement interventions on a timely basis in order to have an effective impact on the overall outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period.

In the 2020 Core Medicaid CM audit, the Plan scored below the 80% standard and has opportunities for improvement in the following categories: Preventive Services (DDD Population; 69% and DCP&P Population; 76%), and Continuity of Care (DDD Population; 76% and DCP&P Population; 72%).

Based on the 2020 MLTSS HCBS CM audit, ABHNJ has opportunities for improvement in the following MLTSS PMs: PM #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), PM #9a (Member's plan of care is amended based on change of member condition), PM #11 (Plans of care developed using "person-centered principles"), and PM #12 (MLTSS HCBS plans of care that contain a back-up plan).

There are opportunities for improvement in regard to Performance Measures:

- Aetna should ensure that the Initial Plans of Care are developed within 45 days of enrollment into the MLTSS program.
- Aetna should ensure that the Member's Plan of Care is amended based on change of member condition, and the Plan of Care is reviewed, signed and dated by the member and/or authorized representative.
- Aetna should ensure that the Plan of Care reflects a member-centric approach, and that the member/member representative is present and involved in the Plan of Care development.
- Aetna should ensure that the MLTSS Home and Community Based Services (HCBS) Plans of Care contain a signed Back-up Plan.

Recommendations

The Plan should continue to contract with hospitals to improve access to care in deficient counties.

The Plan should continue to expand the MLTSS network to include at least two providers in every county.

The Plan should continue to address deficiencies identified in their provider network for adult PCPs, OB/GYNs, and behavioral health providers who fail to meet the required accessibility standards, as well as improve after-hours availability for PCPs.

The Plan should develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.

The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.

The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should ensure they have enough members for the population of their PIPs in order to gather meaningful data.

For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P population include the following:

Recommendations for the Preventive Services Category for the DDD Population include:

- Aetna should ensure EPSDT exams and immunizations are confirmed by a reliable source, such as the PCP, and NJ immunization registry.
- Aetna should ensure that dental needs are addressed for all members, particularly members 21 years of age and older.
- Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.

Recommendations for the Continuity of Care Category for the DDD Population include:

- Aetna should ensure all members receive a Comprehensive Needs Assessment within 45 days of enrollment.
- Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA.

Recommendations for the in Preventive Services Category for the DCP&P Population include:

- Aetna should continue to focus on age-appropriate immunizations for the child population enrolled in care management.
- Aetna should ensure immunizations are confirmed by a reliable source, such as the PCP, NJ immunization registry, DCP&P nurse.
- Aetna should ensure that dental needs are addressed for all members. Care Managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.
- Aetna should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Recommendations for the Continuity of Care Category for the DCP&P Population include:

- Aetna should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment.
- Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

For the 2020 MLTSS HCBS CM audit, recommendations include the following:

Recommendations for the Assessment category include:

- Group D: Aetna should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA). Aetna should confirm the NJCA and PCA assessments are consistent or in agreement, to certify appropriate services are authorized and provided to the member.

Recommendations for the Face-to-Face Visits category include:

- Group C: Aetna should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Aetna should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Aetna should ensure that a cost neutrality analysis is completed during the review period.
- Group D: Aetna should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Aetna should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.
- Group E: Aetna should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Aetna should ensure that a cost neutrality analysis is completed during the review period and the annual cost threshold should be documented as a numeric percentage.

Recommendations for the Initial Plan of Care (Including Back-up Plans) category include:

- Group C: Aetna should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. Aetna should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. Members should be offered options, and provided a choice of MLTSS service delivery including PACE during Options Counseling. Aetna should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative. Aetna should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member and the member/member representative confirmed their understanding. Member's Rights and Responsibilities should be signed and dated by the member/member representative.
- Group D: Aetna should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. Aetna should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged

and addressed in the Plan of Care. Members should be offered options, and provided a choice of MLTSS service delivery including PACE during Options Counseling. Aetna should confirm the State mandated Back-up Plan is completed and signed and dated by the member/member representative.

Recommendations for the Ongoing Care Management category include:

- Group C: Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS Services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that members' Back-up Plans are reviewed, signed and dated at least quarterly for members residing in the Community. Aetna should ensure that Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. The MCO should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.
- Group D: Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS Services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that the Care Managers counsel the members on the written notice of action and explain their right to file an appeal when the member disagrees with their Assessment and or Services Authorizations. Aetna should ensure that members' Back-up Plans are reviewed, signed and dated at least quarterly for members residing in the Community. Aetna should ensure that Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Aetna should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.
- Group E: Aetna should ensure that Care Managers document their actions to resolve any issues that impede members' access to care. Aetna should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and the Face-to-Face visits are completed within the appropriate timeframes. Aetna should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Aetna should ensure that members' Back-up Plans are reviewed, signed and dated at least quarterly for members residing in the Community. Aetna should ensure that the MLTSS Care Manager conducts a Face-to-Face visit within 24 hours for urgent/emergent situations that can't be handed telephonically. Aetna should ensure that the Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Aetna should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.

AGNJ

AGNJ had an enrollment of 237,211 for Core Medicaid and MLTSS as of December 2020, which represented 13% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

AGNJ's compliance score for 11 of 13 reviewed standards in the 2020 Annual Assessment of Operations Review was 100%.

The Plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2019 Annual Assessment of Operations Review.

For HEDIS PMs, the Plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC), Comprehensive Diabetes Care (CDC; HbA1c Poor Control [>9.0], HbA1c Control [<8.0], and HbA1c Control [<7.0] for a Selected Population), Immunizations for Adolescents (IMA; Meningococcal; Tdap/Td; and Combination 1), Chlamydia Screening (CHL), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Adult BMI Assessment (ABA), Metabolic Monitoring for Children and Adolescents on Antipsychotics and Blood Glucose and Cholesterol Testing (APM; 12-17 Years), Follow-up After Emergency Department Visit for Mental Illness (FUM; 18-64 years - 30-Day Follow-up, 18-64 years - 7-Day Follow-up, Total - 30-Day Follow-up and Total - 7-Day Follow-up), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD), Children and Adolescents' Access to Primary Care Practitioners (CAP; 25 months - 6 years, 7-11 years, and 12-19 years), Use of Opioids From Multiple Providers (UOP; Multiple Pharmacies, and Multiple Prescribers and Multiple Pharmacies), and Risk of Continued Opioid Use (COU; 18-64 years - >=15 Days covered, 65+ years - >=15 Days covered, 65+ years - >=31 Days covered, and Total - >=15 Days covered).

In the 2020 Core Medicaid CM audit, AGNJ scored at or above the 80% standard for all four categories (Outreach, Preventive Service, Continuity of Care, Coordination of Services) for both populations (DDD and DCP&P). AGNJ scored 100% in Identification for the DDD and DCP&P population. The MCO also scored 100% in Coordination of Services for the DDD Population.

In the 2020 MLTSS HCBS CM audit, AGNJ scored above 90% for MLTSS PM #9 (Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary), PM #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment), and PM#16 (Member training on identifying/reporting critical incidents).

Opportunities for Improvement

AGNJ scored below 85% compliance in 1 of the 13 standards in the 2020 Annual Assessment of Operations Review. AGNJ scored 64% for Access which was below the 85% standard.

For HEDIS PMs, the measures that had all or most rates below the NCQA 50th percentile present opportunities for improvement.

Review of the Core Medicaid/MLTSS PIPs identified opportunities to implement interventions on a timely basis in order to have an effective impact on the overall outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. Review of the Core Medicaid/MLTSS PIPs identified opportunities to implement interventions on a timely basis as the Plan struggled to identify appropriate start dates. The Plan should review ITMs; the Plan is tracking interventions predominantly in terms of the provider count. This is insufficient, and the Plan should review how interventions are being tracked and develop more meaningful tracking measures.

In the 2020 Core Medicaid CM audit, the Plan did not score below the 80% standard for any of the review categories across both populations.

Based on the 2020 MLTSS HCBS CM audit, AGNJ has opportunities for improvement in the following MLTSS PMs #8 (Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS), PM #9a (Member's Plan of Care is amended based on change of member condition), PM #11 (Plans of Care developed using "person-centered principles"), and PM #12 (MLTSS HCBS plans of care that contain a back-up plan).

There are opportunities for improvement in regard to performance measures:

- Amerigroup should ensure that the Initial Plans of Care are established within 45 days of enrollment into the MLTSS program.
- Amerigroup should ensure the member's Plan of Care is amended based on change of member needs or condition. The Plan of Care should be reviewed, signed and dated by the member and/or authorized representative.

- Amerigroup should ensure the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the Plan of Care development.
- Amerigroup should ensure that the MLTSS Home and Community Based Services (HCBS) Plans of Care contain a signed Back-up Plan.

Recommendations

The Plan should continue to recruit adult PCPs, pediatric PCPs, and contract with hospitals to improve access to care in the deficient counties.

The Plan should continue to expand the MLTSS network to include at least two providers in social adult day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.

The Plan should continue to focus on improving after-hours availability statewide.

The Plan should continue to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers.

The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.

The Plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Core Medicaid/MLTSS PIPs that were active at the end of the review period. The Plan should review Interventions and Intervention Tracking Measures (ITMs), and ensure data is being collected appropriately. The Plan should also follow appropriate timelines throughout the PIPs.

For the 2020 MLTSS HCBS CM audit, recommendations include the following:

Recommendations for the Assessment category include:

- Group D: Amerigroup should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA).

Recommendations for the Member Outreach category include:

- Group D: Amerigroup should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care for the member.

Recommendations for the Face-to-Face Visits category include:

- Group C: Amerigroup should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Amerigroup should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.
- Group D: Amerigroup should ensure the Interim Plan of Care is completed and signed by the member or member's representative. Amerigroup should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Amerigroup should ensure a cost neutrality analysis is completed during the review period and the annual cost threshold should be documented as a numeric percentage.
- Group E: Amerigroup should ensure that the Care Manager documents when the NJCA is completed during the Face-to-Face visit. Amerigroup should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. Amerigroup should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. Amerigroup should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold is documented as a numeric percentage.

Recommendations for the Initial Plan of Care (Including Back-up Plans) category include:

- Group C: Amerigroup should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program.
- Group D: Amerigroup should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. Amerigroup should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. Amerigroup should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative. Amerigroup should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and member.

Recommendations for the Ongoing Care Management category include:

- Group C: Amerigroup should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and that the Face-to-Face visits are completed within the appropriate timeframes.
- Group D: Amerigroup should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period and the face to face visits are completed within the appropriate timeframes.
- Group E: Amerigroup should ensure members receive timely Face-to-Face visits, to review member placement and MLTSS services during the review period and the Face-to-Face visits are completed within the appropriate timeframes. Amerigroup should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. Amerigroup should ensure that Plans of Care are reviewed and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.

HNJH

HNJH had an enrollment of 1,019,574 for Core Medicaid and MLTSS as of December 2020, which represented 55% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

HNJH's compliance score for 11 of 13 reviewed standards in the 2020 Annual Assessment of Operations Review was 100%.

The Plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2020 Annual Assessment of Operations Review.

For HEDIS PMs, the Plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC), Comprehensive Diabetes Care (CDC; Medical Attention for Nephropathy), Immunizations for Adolescents (IMA; Meningococcal, Tdap/Td, Combination 1), Children and Adolescents' Access to Primary Care Practitioners (CAP; 25 Months - 6 Years; 7-11 Years; 12-19 Years), and Annual Dental Visit (ADV; 7-10 Years, 11-14 Years, 15-18 Years, 19-20 Years, Total).

In the 2020 Core Medicaid CM audit, HNJH scored above the 80% standard for two categories (Outreach and Coordination of Services) for the DDD population. The Plan scored above the 80% standard for all four categories (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) for the DCP&P Population. HNJH also scored 100% for Coordination of Services for the DCP&P population.

In the 2020 MLTSS HCBS CM audit, HNJH scored above 90% for MLTSS PM #8 (Initial Plan of Care Established within 45 days of enrollment into MLTSS/HCBS), PM #9 (Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary), PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), PM #11 (Plans of Care developed using "person-centered principles"), PM #12 (MLTSS Home

and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan), and PM #16 (Member training on identifying/reporting critical incidents).

Opportunities for Improvement

For HEDIS PMs, the measures that had all or most rates below the NCQA 50th percentile present opportunities for improvement.

In the 2020 Core Medicaid CM audit, the Plan scored below the 80% standard and has opportunities for improvement in the following elements; Preventive Services (DDD Population; 77%), and Continuity of Care (DDD Population; 79%).

Based on the 2020 MLTSS HCBS CM audit, HNJH has opportunities for improvement in the following MLTSS PM #9a (Member's Plan of Care is amended based on a change of member condition).

There are opportunities for improvement in regard to Performance Measures:

- Horizon should ensure that the member's Plan of Care is amended based on change of member needs or condition. The Plan of Care should be reviewed, signed and dated by the member and/or authorized representative.

Recommendations

The Plan should continue to negotiate a contract with dental providers to improve access to care in the deficient counties.

The Plan should continue to expand the MLTSS network to include at least two providers in every county for adult social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.

The Plan should ensure that Core Medicaid provider grievance resolution letters are sent to the provider in a timely manner.

The Plan should ensure that MLTSS member appeal resolution letters are sent to members in a timely manner.

The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.

The Plan should ensure that the MLTSS Gaps in Care PIP implements interventions on a timely basis in order to have an effective impact on the overall outcome at the end of the review period.

For the 2020 Core Medicaid CM Audit, recommendations for the DDD & DCP&P Populations include the following:

Recommendations for the Preventive Services Category for the DDD Population include:

- Horizon should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry, should be consistently documented. Care managers should ensure members 18 years of age and older receive appropriate vaccines.
- Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.
- Horizon should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Recommendations for the Continuity of Care Category for the DDD Population include:

- Horizon should ensure all members receive a Comprehensive Needs Assessment. Care managers should ensure a Comprehensive Needs Assessment is completed within 45 days of enrollment.

- Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

For the 2020 MLTSS HCBS CM audit, recommendations include the following:

Recommendations for Member Outreach category include:

- Group D: Horizon should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care for the member.

Recommendations for the Face-to-Face Visits category include:

- Group E: Horizon should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. Horizon should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage. Horizon should ensure that members at or above 85% of the ACTs should have a pre-call meeting and IDT meeting within the appropriate timeframes.

Recommendations for the Ongoing Care Management category include:

- Group E: Horizon should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period. Horizon should also ensure that the Face-to-Face visits are completed within the appropriate timeframes. Horizon should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is provided with a copy of the Plan of Care at each visit. Horizon should ensure that the Care Managers counsel the members on the written notice of action and explains their right to file an appeal when the member disagrees with their Assessment and/or service authorizations. Horizon should ensure that Face-to-Face visits from the member's Care Manager are completed within 10 business days of discharge from an institutional facility to a HCBS setting. Horizon should ensure that Plans of Care are reviewed, and/or amended and signed by the member/member representative upon any significant change of the member's needs or condition.

UHCCP

UHCCP reported an enrollment of 374,357 for Core Medicaid and MLTSS as of December 2020, which represented 20% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

UHCCP's compliance score for 6 of 13 reviewed standards in the 2020 Annual Assessment of Operations Review was 100%.

The Plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2020 Annual Assessment of Operations Review.

For HEDIS PMs, the Plan exceeded the 75th percentile for the following measures: Adolescent Well-Care Visits (AWC), Comprehensive Diabetes Care (CDC; HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population, Medical Attention for Nephropathy), Persistence of Beta-Blocker Treatment After a Heart Attack (PBH), Statin Therapy for Patients with Cardiovascular Disease (SPC; 21-75 years (Male) - Statin Adherence 80% , 40-75 years (Female) - Statin Adherence 80% , Total - Statin Adherence 80%), Immunizations for Adolescents (IMA; Tdap/Td, Combination 1); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; BMI percentile - 12-17 Years), Metabolic Monitoring for Children and Adolescents on Antipsychotics and Blood Glucose and Cholesterol Testing (APM; 12-17 Years), Antidepressant Medication Management (AMM; Effective Acute Phase Treatment), Follow-up After Emergency Department Visit for Mental Illness (FUM; 18-64 years - 30-Day Follow-Up, 18-64 years - 7-Day Follow-Up, 65+ years - 7-Day Follow-Up, Total - 7 Day Follow-Up), Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD), Adolescents' Access to Primary Care Practitioners (CAP; 25

Months - 6 Years, 7-11 Years), Adults' Access to Preventive/Ambulatory Health Services (AAP; 65+ Years), Annual Dental Visit (ADV; 2-3 Years, 4-6 Years, 7-10 Years, 11-14 Years, 15-18 Years, 19-20 Years, Total), and Use of Opioids From Multiple Providers (UOP; Multiple Prescribers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies).

In the 2020 Core Medicaid CM audit, UHCCP scored above the 80% standard for two categories for the DDD Population (Outreach and Coordination of Services) and all four categories for the DCP&P Population (Outreach, Preventive Service, Continuity of Care, and Coordination of Services). The Plan scored 100% in the Outreach category for the DDD Population and 100% in the Coordination of Services category for the DCP&P population.

In the 2020 MLTSS HCBS CM audit, UHCCP scored above 90% for MLTSS PMs #9 (Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary), PM #9a (Member's Plan of Care is amended based on change of member condition), PM #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment), and PM #16 (Member training on identifying/reporting critical incidents).

Opportunities for Improvement

UHCCP received a compliance score of 71% for Access, 80% for Efforts to Reduce Healthcare Disparities, and 80% for Credentialing and Re-credentialing, which were below the 85% standard.

For HEDIS PMs, the measures that had all or most rates below the NCQA 50th percentile present opportunities for improvement.

Review of UHCCP's MLTSS Gap in Care PIP identified concerns related to goal setting for targeted improvement which impacts its feasibility. The baseline rate does not align with the PIP's implementation and measurement timeframes as noted in the revised methodology.

In the 2020 Core Medicaid CM audit, the Plan scored below 80% and has opportunities for improvement in the following elements; Preventive Services (DDD Population; 73%), and Continuity of Care (DDD Population; 78%).

Based on the 2020 MLTSS HCBS CM audit, UHCCP has opportunities for improvement in the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), PM #11 (Plans of care developed using "person-centered principles), and PM #12 MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan).

There are opportunities for improvement in regard to Performance Measures:

- UnitedHealthcare should ensure that the Initial Plans of Care are established within 45 days of enrollment into the MLTSS program.
- UnitedHealthcare should ensure the Plan of Care reflects a member-centric approach and that the member/member representative is present and involved in the Plan of Care development.
- UnitedHealthcare should ensure that the MLTSS Home and Community Based Services (HCBS) Plans of Care contain a signed Back-up Plan.

Recommendations

The Plan should continue to recruit adult PCP, pediatric specialists and contract with hospitals to improve access to care in the deficient counties, as well as monitor adequate access to adult PCP urgent care and after hours access. Where no specialists are available in these counties, the MCO should delineate how specialty care for children in these counties is provided.

The Plan should work with the obstetric network to ensure adequate access to prenatal care. Providers not meeting the standard should be requested to submit a corrective action plan (CAP) and should be re-evaluated.

The Plan should ensure adequate access to emergency appointments for dental providers, as well as after-hours access.

The Plan should ensure adequate access to behavioral health providers for urgent and routine care appointments.

The Plan should continue to expand the MLTSS network to include at least two providers in every county for and assisted living in Hudson County. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.

The MCO should develop reporting around aspiration pneumonia, injuries, fractures, contusions, decubiti and seizure management for the broader Medicaid population.

The Plan should ensure MLTSS member grievance resolution letters are sent to members in a timely manner.

The Plan should ensure review of quality metrics, including a review of complaints/quality issues, at the time of recredentialing, and that this is documented in the Core Medicaid PCP recredentialing files.

The Plan should ensure dental policies are reviewed annually and/or during the review period.

The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.

The Plan should ensure the MLTSS Gaps in Care PIP addresses revised timeframes and reporting schedules to ensure targeted improvements can be evaluated appropriately, in terms of performance over time.

For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations include the following:

Recommendations for the Preventive Services Category for the DDD Population include:

- UnitedHealthcare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood EPSDT exams and immunizations from a reliable source, such as the PCP, and NJ immunization registry, should be consistently documented.
- Care managers should ensure members 18 years of age and older receive appropriate vaccines.
- Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.
- UnitedHealthcare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Recommendations for the Continuity of Care Category for the DDD Population include:

- UnitedHealthcare should ensure all members receive a Comprehensive Needs Assessment within 45 days of enrollment.
- Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstances.

For the 2020 MLTSS HCBS CM audit, recommendations include the following:

Recommendations for the Assessment category include:

- Group D: UnitedHealthcare should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA).

Recommendations for the Member Outreach category include:

- Group C: UnitedHealthcare should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care.
- Group D: UnitedHealthcare should ensure that the Care Manager outreaches to the member within five business days of MLTSS enrollment to schedule a Face-to-Face visit to create a Plan of Care.

Recommendations for the Face-to-face Visits category include:

- Group C: UnitedHealthcare should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.
- Group D: UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.
- Group E: UnitedHealthcare should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. UnitedHealthcare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct. UnitedHealthcare should ensure that a cost neutrality analysis is completed during the review period, and that the annual cost threshold is documented as a numeric percentage.

Recommendations for the Initial Plan of Care (Including Back-up Plans) category include:

- Group C: UnitedHealthcare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. UnitedHealthcare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member. UnitedHealthcare should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member, and the member/member representative confirmed their understanding. Member's Rights and Responsibilities should be signed and dated by the member/member representative.
- Group D: UnitedHealthcare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. UnitedHealthcare should ensure that the Plan of Care reflects a member-centric approach, and the member/member representative is present and involved in the development and modification of agreed upon goals, is given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the Plan of Care. UnitedHealthcare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member.

Recommendations for the Ongoing Care Management category include:

- Group C: UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the face to face visits are completed within the appropriate timeframes. UnitedHealthcare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis.
- Group D: UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes.
- Group E: UnitedHealthcare should ensure that Care Managers document their actions to resolve any issues that impede members' access to care. UnitedHealthcare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and the Face-to-Face visits are completed within the appropriate timeframes. UnitedHealthcare should ensure that appropriate documentation is completed when the Initial Plan of Care requires changes and that the Plans of Care are reviewed and/or revised. They should ensure that the member agrees or disagrees with the Plan of Care, and that the member signs and is

provided with a copy of the Plan of Care at each visit. UnitedHealthcare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. UnitedHealthcare should ensure that a Face-to-Face visit from the member's Care Manager is completed within 10 business days of discharge from an institutional facility to a HCBS setting.

WCHP

WCHP reported an enrollment of 99,857 for Core Medicaid and MLTSS as of December 2020, which represented 5% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

WCHP's compliance score for 10 of 13 reviewed standards in the 2020 Annual Assessment of Operations Review was 100%.

The Plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2020 Annual Assessment of Operations Review.

For HEDIS PMs, the Plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34), Adolescent Well-Care Visits (AWC), Comprehensive Diabetes Care (CDC; HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population, Medical Attention for Nephropathy), Statin Therapy for Patients with Cardiovascular Disease (SPC; 40-75 years (Female) - Statin Adherence 80%), Immunizations For Adolescents (IMA; Tdap/Td), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; BMI percentile - 3-11 Years, BMI percentile - 12-17 Years, BMI percentile – Total, Counseling for Nutrition - 3-11 Years, Counseling for Nutrition - 12-17 Years, Counseling for Nutrition – Total), Adult BMI Assessment (ABA), Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA), Children and Adolescents' Access to Primary Care Practitioners (CAP); 25 Months - 6 Years, 7-11 Years, 12-19 Years, Adults' Access to Preventive/Ambulatory Health Services (AAP; 65+ Years), Annual Dental Visit (ADV; 2-3 Years), Use of Opioids From Multiple Providers (UOP; Multiple Prescribers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies).

In the 2020 Core Medicaid CM audit, WCHP scored above the 80% standard for two categories (Outreach and Coordination of Services) for the DDD Population and three categories (Outreach, Continuity of Care, and Coordination of Services) for the DCP&P Population. WCHP scored 100% for Coordination of Services category for the DCP&P population.

In the 2020 MLTSS HCBS CM audit, WCHP scored above 90% for MLTSS PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), PM #12 (MLTSS Home and Community Based Services [HCBS] plans of care that contain a back-up plan) and PM #16 (Member training on identifying/reporting critical incidents).

Opportunities for Improvement

WCHP received a compliance score of 80% for Satisfaction in the 2020 Annual Assessment of Operations Review, which was below the 85% standard.

For HEDIS PMs, the measures that had all or most rates below the NCQA 50th percentile present opportunities for improvement.

In the 2020 Core Medicaid CM audit, the Plan scored below 80% and has opportunities for improvement in the following elements; Preventive Services (DDD Population; 73%), Continuity of Care (DDD Population; 74%), Preventive Services (DCP&P Population; 75%).

Based on the 2020 MLTSS HCBS CM audit, WCHP has opportunities for improvement in the following MLTSS PMs: #8 (Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS), and PM #11 (Plans of Care developed using "person-centered principles").

There are opportunities for improvement in regard to Performance Measures:

- WellCare should ensure that Initial Plans of Care are established within 45 days of enrollment into the MLTSS program.
- WellCare should ensure that the Plan of Care reflects a member-centric approach and that the member/member representative is present and involved in the Plan of Care development.

Recommendations

The Plan should continue to recruit dental providers to improve access to care in the deficient counties.

The Plan should continue to expand the MLTSS network to include at least two providers in every county for assisted living and social day care. The Plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.

The Plan should address areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile.

The Plan should produce quarterly surveys for new enrollees, in person, by phone, or other means to adhere to Contract requirements.

The Plan should ensure that Core Medicaid member appeal resolution letters are correct and sent to the members in a timely manner.

The Plan should ensure that MLTSS provider grievances resolution letters are sent to the providers in a timely manner.

For the 2020 Core Medicaid CM Audit, recommendations for the DDD and DCP&P Populations include the following:

Recommendations for the Preventive Services Category for the DDD Population include:

- WellCare should ensure members 18 years of age and above receive appropriate vaccines. Care managers should document all aggressive outreach attempts to obtain immunization for members 18 years of age and above.
- Care Managers should address all dental needs for members 21 years of age and older. WellCare should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age.
- WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

Recommendations for the Continuity of Care Category for the DDD Population include:

- WellCare should ensure all members receive a Comprehensive Needs Assessment. Care managers should develop and implement a care plan with all required components within 30 days of a completed CNA. Care managers should continually assess and update the care plan to accurately reflect the member's needs or circumstance.

Recommendations for the Preventive Services Category for the DCP&P Population include:

- WellCare should continue to focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of immunizations from a reliable source, such as the PCP, NJ immunization registry, and DCP&P nurse if appropriate, should be consistently documented.
- Care managers should provide dental education and document the date of the member's annual dental visit for members from 1 to 21 years of age. WellCare should ensure members between the ages of 9 months and 72 months are appropriately tested for lead to ensure contract adherence.

For the 2020 MLTSS HCBS CM audit, recommendations include the following:

Recommendations for the Assessment category include:

- Group D: WellCare should ensure that a screening tool; utilized to identify potential MLTSS needs is completed prior to the initial New Jersey Choice Assessment (NJCA). WellCare should ensure that the NJCA is submitted to OCCO within five business days of the completed assessment.

Recommendations for the Face-to-Face Visits category include:

- Group C: WellCare should ensure that the Interim Plan of Care is completed and signed by the member or member's representative. WellCare should ensure that the participant direction application packet is submitted to DMAHS by the MCO within 10 business days of the member's request to self-direct.
- Group E: WellCare should ensure that the Care Manager documents when the NJCA was completed during the Face-to-Face visit. WellCare should ensure that a cost neutrality analysis is completed during the review period, and the annual cost threshold is documented as a numeric percentage. WellCare should ensure members at or above 85% of the ACTs should have a pre-call meeting and IDT meeting within the appropriate timeframes.

Recommendations for the Initial Plan of Care (Including Back-up Plans) category include:

- Group C: WellCare should ensure that the Initial Plan of Care is completed and signed within 45 days of enrollment in the MLTSS program. WellCare should confirm the State mandated Back-up Plan is completed, signed and dated by the member/member representative. WellCare should ensure that when the Care Manager identifies a risk, a risk management agreement is completed, signed and dated by the CM and the member. WellCare should ensure that the member received his/her Rights and Responsibilities in writing during the review period, the Rights and Responsibilities were explained to the member, and the member/member representative confirmed their understanding. The member's Rights and Responsibilities should be signed and dated by the member/member representative.

Recommendations for the Ongoing Care Management category include:

- Group C: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes.
- Group D: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis.
- Group E: WellCare should ensure that members receive timely Face-to-Face visits to review member placement and MLTSS services during the review period, and that the Face-to-Face visits are completed within the appropriate timeframes. WellCare should ensure that members who were enrolled long enough for a quarterly update, and had services that required a Back-up Plan, had their Back-up Plan reviewed with the member at least once on a quarterly basis. WellCare should ensure that a Face-to-Face visit from the member's Care Manager is completed within 10 business days of discharge from an institutional facility to a HCBS setting.

APPENDIX: January 2020–December 2020 MCO-Specific Review Findings

Appendix Table of Contents

ABHNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

ABHNJ 2020 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	10	10	7	11	3	0	79%	3	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	19	16	10	8	17	2	0	89%	2	0	0
Efforts to Reduce Healthcare Disparities	5	4	5	5	5	0	0	100%	0	1	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	9	5	5	11	0	0	100%	0	2	0
Satisfaction	5	4	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	9	4	4	10	0	0	100%	0	1	0
Utilization Management	30	26	14	13	29	0	1	100%	0	4	0
Administration and Operations	13	13	3	3	13	0	0	100%	0	0	0
Management Information Systems	18	17	4	4	18	0	0	100%	0	0	0
TOTAL	**196**	**179**	**86**	**80**	**190**	**5**	**1**	**97%**	**5**	**9**	**0**

[1] All existing elements were subject to review in the previous review period. The Care Management and Continuity of Care category was removed from the 2020 AA and scored and reviewed independently of the AA.

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

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

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

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

ABHNJ Performance Improvement Projects

ABHNJ PIP 1: Improving Developmental Screening and Referral Rates to Early Intervention for Children

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings[3]	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		PM	M	M	
1b. Impacts the maximum proportion of members that is feasible		M	NM	NM	
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	NM	M	
1d. Reflects high-volume or high risk-conditions		M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	M	M	
Element 1 Overall Review Determination		**PM**	**PM**	**PM**	
Element 1 Overall Score		**50.0**	**50.0**	**50.0**	
Element 1 Weighted Score		**2.5**	**2.5**	**2.5**	
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	PM	PM	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		PM	M	M	
2c. Objectives align aim and goals with interventions		M	PM	M	
Element 2 Overall Review Determination		**PM**	**PM**	**PM**	
Element 2 Overall Score		**50.0**	**50.0**	**50.0**	
Element 2 Weighted Score		**2.5**	**2.5**	**2.5**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	PM	PM	
3b. Performance indicators are measured consistently over time		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	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		PM	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability		M	M	M	

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings[3]	Final Report Findings
(IRR)]					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	PM	PM	
3h. Study design specifies data analysis procedures with a corresponding timeline		M	PM	M	
Element 3 Overall Review Determination		**PM**	**PM**	**PM**	
Element 3 Overall Score		**50.0**	**50.0**	**50.0**	
Element 3 Weighted Score		**7.5**	**7.5**	**7.5**	
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	
4c. Provider input at focus groups and/or Quality Meetings		M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M	M	
4f. Literature review		M	PM	M	
Element 4 Overall Review Determination		**M**	**PM**	**M**	
Element 4 Overall Score		**100.0**	**50.0**	**100**	
Element 4 Weighted Score		**15.0**	**7.5**	**15.0**	
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M	N/A	
5b. Actions that target member, provider and MCO		M	M	N/A	
5c. New or enhanced, starting after baseline year		M	M	N/A	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	NM	N/A	
Element 5 Overall Review Determination		**M**	**PM**	**N/A**	
Element 5 Overall Score		**100.0**	**50.0**	**N/A**	

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings[3]	Final Report Findings
Element 5 Weighted Score		**15.0**	**7.5**	**N/A**	
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	PM	M	
Element 6 Overall Review Determination		**M**	**PM**	**M**	
Element 6 Overall Score		**100.0**	**50.0**	**100**	
Element 6 Weighted Score		**5.0**	**2.5**	**5.0**	
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		PM	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	PM	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	PM	NM	
7d. Lessons learned & follow-up activities planned as a result		M	M	M	
Element 7 Overall Review Determination		**PM**	**PM**	**PM**	
Element 7 Overall Score		**50.0**	**50.0**	**50.0**	
Element 7 Weighted Score		**10.0**	**10.0**	**10.0**	
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A	NM	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A	M	
Element 8 Overall Review Determination		**N/A**	**N/A**	**PM**	
Element 8 Overall Score		**N/A**	**N/A**	**50.0**	
Element 8 Weighted Score		**N/A**	**N/A**	**10.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		**M**	**Y**	**Y**	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report

Aetna Better Health of New Jersey (ABHNJ) PIP 1 Topic: Improving Developmental Screening and Referral Rates to Early Intervention for Children	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings[3]	Final Report Findings
					Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**N/A**
Actual Weighted Total Score	**N/A**	**57.5**	**40.0**	**52.5**	**N/A**
Overall Rating	**N/A**	**71.9%**	**50%**	**61.8%**	**N/A**

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

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

[2] Aetna resubmitted their Year 1 Findings August PIP submission and this scoring reflects the updated resubmission.

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

ABHNJ PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

Aetna Better Health of New Jersey (ABHNJ) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	PM		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 1 Overall Score	**N/A**	**50.0**	**50**		
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		PM	PM		

Aetna Better Health of New Jersey (ABHNJ) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 2 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 2 Overall Score	**N/A**	**50.0**	**50**		
Element 2 Weighted Score	**N/A**	**2.5**	**2.5**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		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.		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		M	PM		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 3 Overall Score	**N/A**	**50.0**	**50**		
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data (“5 Why’s”, fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		

Aetna Better Health of New Jersey (ABHNJ) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 4 Overall Score	**N/A**	**100.0**	**100**		
Element 4 Weighted Score	**N/A**	**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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM	M		
Element 6 Overall Review Determination	**N/A**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**50.0**	**100**		
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A	M		
7d. Lessons learned & follow-up activities planned as a result		N/A	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**		
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					

Aetna Better Health of New Jersey (ABHNJ) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**42.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**65.4%**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored

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

ABHNJ PIP 3: Non-Clinical Improving Access and Availability

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

Aetna Better Health of New Jersey (ABHNJ) **PIP 3 Topic: Non-Clinical Improving Access and Availability**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline					
3h. Study design specifies data analysis procedures with a corresponding timeline					
Element 3 Overall Review Determination	**N/A**				
Element 3 Overall Score	**N/A**				
Element 3 Weighted Score	**N/A**				
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach					
4c. Provider input at focus groups and/or Quality Meetings					
4d. QI Process data ("5 Why's", fishbone diagram)					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)					
4f. Literature review					
Element 4 Overall Review Determination	**N/A**				
Element 4 Overall Score	**N/A**				
Element 4 Weighted Score	**N/A**				
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis					
5b. Actions that target member, provider and MCO					
5c. New or enhanced, starting after baseline year					
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)					
Element 5 Overall Review Determination	**N/A**				
Element 5 Overall Score	**N/A**				
Element 5 Weighted Score	**N/A**				
Element 6. Results Table (15% 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				

Aetna Better Health of New Jersey (ABHNJ) PIP 3 Topic: Non-Clinical Improving Access and Availability	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 6 Overall Review Determination	**N/A**				
Element 6 Overall Score	**N/A**				
Element 6 Weighted Score	**N/A**				
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.					
7d. Lessons learned & follow-up activities planned as a result					
Element 7 Overall Review Determination	**N/A**				
Element 7 Overall Score	**N/A**				
Element 7 Weighted Score	**N/A**				
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**				
Element 8 Overall Score	**N/A**				
Element 8 Weighted Score	**N/A**				
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	**N**				

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

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

ABHNJ PIP 4: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)

Aetna Better Health of New Jersey (ABHNJ) **PIP 4 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	PM		
Element 1 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 1 Overall Score	**N/A**	**50.0**	**50**		
Element 1 Weighted Score	**N/A**	**2.5**	**2.5**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		
Element 2 Weighted Score	**N/A**	**5.0**	**5**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		PM	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		

Aetna Better Health of New Jersey (ABHNJ) **PIP 4 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50.0**	**100**		
Element 3 Weighted Score	**N/A**	**7.5**	**15**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100.0**	**100**		
Element 4 Weighted Score	**N/A**	**15.0**	**15**		
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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding		NM	PM		

Aetna Better Health of New Jersey (ABHNJ) PIP 4 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
goals					
Element 6 Overall Review Determination	**N/A**	**NM**	**PM**		
Element 6 Overall Score	**N/A**	**0**	**50**		
Element 6 Weighted Score	**N/A**	**0.0**	**2.5**		
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	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A	M		
7d. Lessons learned & follow-up activities planned as a result		N/A	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**0**	**50**		
Element 7 Weighted Score	**N/A**	**0.0**	**10**		
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		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**50.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**76.9%**	**N/A**	**N/A**

Aetna Better Health of New Jersey (ABHNJ) PIP 4 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Proposal Findings were not scored.
[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (for Year 2 findings phase).

ABHNJ Care Management Audits

ABHNJ 2020 (MY 2019) Core Medicaid Care Management Audit

Determination by Category	DDD	DCP&P
	2019 (n=27)	2019 (n=71)
Outreach	100%	99%
Preventive Services	69%	76%
Continuity of Care	76%	72%
Coordination of Services	100%	99%

ABHNJ 2020 Summary of Findings for Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Aetna	30	26	4	87%

ABHNJ MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020

Performance Measure	Group[1]	July 2019 – February 2020		
		D	N	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	55	24	43.6%
	Group D	39	23	59.0%
	Group E			
	Total	94	47	50.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	13	12	92.3%
	Total	13	12	92.3%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	1	0	0.0%
	Group D	1	0	0.0%
	Group E	2	1	50.0%
	Total	4	1	25.0%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	43	43	100.0%
	Group D	27	25	92.6%
	Group E	13	12	92.3%
	Total	83	80	96.4%
#11. Plans of Care developed using "person-centered principles" [6]	Group C	43	0	0.0%
	Group D	27	0	0.0%
	Group E	30	16	53.3%
	Total	100	16	16.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	29	22	75.9%
	Group D	27	18	66.7%
	Group E	26	24	92.3%
	Total	82	64	78.0%
#16. Member training on identifying/reporting critical incidents	Group C	43	42	97.7%
	Group D	27	25	92.6%
	Group E	30	30	100.0%
	Total	100	97	97.0%

[1]Group C is made up of members new to managed care and newly eligible to MLTSS. Group D is made up of current members newly enrolled to MLTSS. Group E is made up of members enrolled in the MCO and MLTSS prior to the review period.

[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.

[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.

[4]Members who did not have a documented change in condition during the study period are excluded from this measure.

[5]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[6]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

ABHNJ MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020 – Results by Category

Determination by Category	Group C	Group D	Group E[1]	Combined[2]
Assessment	100.0%	55.4%	90.9%	74.0%
Outreach	100.0%	100.0%		100.0%
Face-to-Face Visits	82.1%	84.5%	69.0%	79.4%
Initial Plan of Care (Including Back-up Plans)	74.9%	79.7%	88.7%	80.3%
Ongoing Care Management	76.1%	71.8%	33.3%	63.6%
Gaps in Care/Critical Incidents	98.6%	96.3%	100.0%	98.4%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS
[2]Calculated as an aggregate score by combining elements applicable to each category

ABHNJ 2020 Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Aetna	10	9	1	90%

ABHNJ 2020 Nursing Facility Audit

Due to the COVID-19 Pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2020 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	9	10	5	9	5	0	64%	5	0	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	19	16	10	9	18	1	0	95%	1	1	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	4	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	29	14	14	30	0	0	100%	0	1	0
Administration and Operations	13	13	3	3	13	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**196**	**186**	**83**	**77**	**190**	**6**	**0**	**97%**	**6**	**2**	**0**

[1] All existing elements were subject to review in the previous review period. The Care Management and Continuity of Care category was removed from the 2020 AA and scored and reviewed independently of the AA.

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

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

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

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

AGNJ Performance Improvement Projects

AGNJ PIP 1: Reduction of the Amerigroup Preterm Birth Rate by 5%

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

Amerigroup New Jersey, Inc. (AGNJ) **PIP 1 Topic: Reduction of the Amerigroup Preterm Birth Rate by 5%**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings [1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
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			M	M	PM
3h. Study design specifies data analysis procedures with a corresponding timeline			M	M	M
Element 3 Overall Review Determination			**PM**	**PM**	**PM**
Element 3 Overall Score			**50.0**	**50.0**	**50.0**
Element 3 Weighted Score			**7.5**	**7.5**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics			M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach			M	M	M
4c. Provider input at focus groups and/or Quality Meetings			M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)			M	M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)			N/A	M	M
4f. Literature review			M	M	M
Element 4 Overall Review Determination			**M**	**M**	**M**
Element 4 Overall Score			**100**	**100**	**100**
Element 4 Weighted Score			**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b. **(15% weight)**					
5a. Informed by barrier analysis			M	M	M
5b. Actions that target member, provider and MCO			M	M	M
5c. New or enhanced, starting after baseline year			PM	M	PM
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)			PM	PM	M
Element 5 Overall Review Determination			**PM**	**PM**	**PM**
Element 5 Overall Score			**50.0**	**50.0**	**50**
Element 5 Weighted Score			**7.5**	**7.5**	**7.5**
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals			PM	PM	PM
Element 6 Overall Review Determination			**PM**	**PM**	**PM**

Amerigroup New Jersey, Inc. (AGNJ) PIP 1 Topic: Reduction of the Amerigroup Preterm Birth Rate by 5%	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings [1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 6 Overall Score			**50.0**	**50.0**	**50**
Element 6 Weighted Score			**2.5**	**2.5**	**2.5**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)			PM	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan			M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.			M	PM	PM
7d. Lessons learned & follow-up activities planned as a result			PM	M	M
Element 7 Overall Review Determination			**PM**	**PM**	**PM**
Element 7 Overall Score			**50.0**	**50.0**	**50.0**
Element 7 Weighted Score			**10.0**	**10.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented			N/A	N/A	PM
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods			N/A	N/A	PM
Element 8 Overall Review Determination			**N/A**	**N/A**	**PM**
Element 8 Overall Score			**N/A**	**N/A**	**50.0**
Element 8 Weighted Score			**N/A**	**N/A**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities (Not scored)**					
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			**80.0**	**80.0**	**100.0**
Actual Weighted Total Score			**50.0**	**50.0**	**60.0**
Overall Rating			**62.5%**	**62.5%**	**60.0%**

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

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

AGNJ PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2 Topic: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M	M	
1b. Impacts the maximum proportion of members that is feasible		M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M	M	
1d. Reflects high-volume or high risk-conditions		M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M	M	
Element 1 Overall Review Determination		**M**	**M**	**M**	
Element 1 Overall Score		**100.0**	**100.0**	**100**	
Element 1 Weighted Score		**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	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M	M	
2c. Objectives align aim and goals with interventions		M	M	M	
Element 2 Overall Review Determination		**M**	**M**	**M**	
Element 2 Overall Score		**100.0**	**100.0**	**100**	
Element 2 Weighted Score		**5.0**	**5.0**	**5.0**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	M	M	
3b. Performance indicators are measured consistently over time		PM	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	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound		M	M	M	

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2 Topic: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M	M	
Element 3 Overall Review Determination		**PM**	**M**	**M**	
Element 3 Overall Score		**50.0**	**100.0**	**100**	
Element 3 Weighted Score		**7.5**	**15.0**	**15.0**	
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		PM	PM	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	
4c. Provider input at focus groups and/or Quality Meetings		M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		N/A	M	M	
4f. Literature review		M	M	M	
Element 4 Overall Review Determination		**PM**	**PM**	**M**	
Element 4 Overall Score		**50.0**	**50.0**	**100**	
Element 4 Weighted Score		**7.5**	**7.5**	**15.0**	
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M	N/A	
5b. Actions that target member, provider and MCO		M	M	N/A	
5c. New or enhanced, starting after baseline year		M	M	N/A	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	PM	N/A	
Element 5 Overall Review Determination		**PM**	**PM**	**N/A**	
Element 5 Overall Score		**50.0**	**50.0**	**N/A**	
Element 5 Weighted Score		**7.5**	**7.5**	**N/A**	
Element 6. Results Table (5% weight)					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2 Topic: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M	M	
Element 6 Overall Review Determination		**M**	**M**	**M**	
Element 6 Overall Score		**100.0**	**100.0**	**100**	
Element 6 Weighted Score		**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)		PM	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		PM	M	M	
7d. Lessons learned & follow-up activities planned as a result		PM	M	NM	
Element 7 Overall Review Determination		**PM**	**M**	**PM**	
Element 7 Overall Score		**50.0**	**100.0**	**50.0**	
Element 7 Weighted Score		**10.0**	**20.0**	**10.0**	
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A	PM	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A	M	
Element 8 Overall Review Determination		**N/A**	**N/A**	**PM**	
Element 8 Overall Score		**N/A**	**N/A**	**50.0**	
Element 8 Weighted Score		**N/A**	**N/A**	**10.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y	**Y**	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**N/A**
Actual Weighted Total Score	**N/A**	**47.5**	**65.0**	**65.0**	**N/A**

Amerigroup New Jersey, Inc. (AGNJ) PIP 2 Topic: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Overall Rating	**N/A**	**59.0%**	**81.3%**	**76.5%**	**N/A**

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

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

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

AGNJ PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative

Amerigroup New Jersey, Inc. (AGNJ) PIP 3 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	M	**M**		
Element 1 Overall Score	**N/A**	**100.0**	**100**		
Element 1 Weighted Score	**N/A**	**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		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	M	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 3 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		PM	PM		
Element 3 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 3 Overall Score	**N/A**	**50.0**	**50**		
Element 3 Weighted Score	**N/A**	**7.5**	**7.5**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data (“5 Why’s”, fishbone diagram)		PM	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**PM**	**M**		
Element 4 Overall Score	**N/A**	**50.0**	**100**		
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 3 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	PM		
Element 6 Overall Review Determination	**N/A**	**M**	**PM**		
Element 6 Overall Score	**N/A**	**100.0**	**50**		
Element 6 Weighted Score	**N/A**	**5.0**	**2.5**		
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	PM		
7d. Lessons learned & follow-up activities planned as a result		N/A	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**		
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable		N/A	N/A		

Amerigroup New Jersey, Inc. (AGNJ) PIP 3 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
time periods					
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**45.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**69.2%**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored

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

AGNJ PIP 4: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

Amerigroup New Jersey, Inc. (AGNJ) PIP 4 Topic: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	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					
1b. Impacts the maximum proportion of members that is feasible					
1c. Potential for meaningful impact on member health, functional status or satisfaction					
1d. Reflects high-volume or high risk-conditions					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)					
Element 1 Overall Review Determination	**N/A**				

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4 Topic: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1 Overall Score	**N/A**				
Element 1 Weighted Score	**N/A**				
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark					
2c. Objectives align aim and goals with interventions					
Element 2 Overall Review Determination	**N/A**				
Element 2 Overall Score	**N/A**				
Element 2 Weighted Score	**N/A**				
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)					
3b. Performance indicators are measured consistently over time					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]					
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.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline					
3h. Study design specifies data analysis procedures with a corresponding timeline					
Element 3 Overall Review Determination	**N/A**				
Element 3 Overall Score	**N/A**				
Element 3 Weighted Score	**N/A**				
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4 Topic: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach					
4c. Provider input at focus groups and/or Quality Meetings					
4d. QI Process data ("5 Why's", fishbone diagram)					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)					
4f. Literature review					
Element 4 Overall Review Determination	**N/A**				
Element 4 Overall Score	**N/A**				
Element 4 Weighted Score	**N/A**				
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis					
5b. Actions that target member, provider and MCO					
5c. New or enhanced, starting after baseline year					
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)					
Element 5 Overall Review Determination	**N/A**				
Element 5 Overall Score	**N/A**				
Element 5 Weighted Score	**N/A**				
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals					
Element 6 Overall Review Determination	**N/A**				
Element 6 Overall Score	**N/A**				
Element 6 Weighted Score	**N/A**				
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4 Topic: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.					
7d. Lessons learned & follow-up activities planned as a result					
Element 7 Overall Review Determination	**N/A**				
Element 7 Overall Score	**N/A**				
Element 7 Weighted Score	**N/A**				
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**				
Element 8 Overall Score	**N/A**				
Element 8 Weighted Score	**N/A**				
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N				

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

[1]Proposal Findings were not scored

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

AGNJ PIP 5: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5 Topic: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100.0**	**100**		
Element 1 Weighted Score	**N/A**	**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		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		PM	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**PM**	**M**		
Element 2 Overall Score	**N/A**	**50.0**	**100**		
Element 2 Weighted Score	**N/A**	**2.5**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		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		M	M		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5 Topic: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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		M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100.0**	**100**		
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	PM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**PM**		
Element 4 Overall Score	**N/A**	**100.0**	**50**		
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**		
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		PM	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight)					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5 Topic: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM	PM		
Element 6 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 6 Overall Score	**N/A**	**50.0**	**50**		
Element 6 Weighted Score	**N/A**	**2.5**	**2.5**		
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		
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**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50.0**		
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	**N**		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**

Amerigroup New Jersey, Inc. (AGNJ) PIP 5 Topic: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Actual Weighted Total Score	**N/A**	**47.5**	**45.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**79.2%**	**69.2%**	**N/A**	**N/A**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Proposal Findings were not scored
[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during the PIP Year 2 Findings Phase)

AGNJ PIP 6: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)

Amerigroup New Jersey, Inc. (AGNJ) PIP 6 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	M		
Element 1 Overall Review Determination	**N/A**	**PM**	**M**		
Element 1 Overall Score	**N/A**	**50.0**	**100**		
Element 1 Weighted Score	**N/A**	**2.5**	**5.0**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 6 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50.0**	**100**		
Element 3 Weighted Score	**N/A**	**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		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	NM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 6 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 4 Overall Review Determination	**N/A**	**M**	**PM**		
Element 4 Overall Score	**N/A**	**100.0**	**50**		
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**		
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		NM	NM		
Element 6 Overall Review Determination	**N/A**	**NM**	**NM**		
Element 6 Overall Score	**N/A**	**0**	**0**		
Element 6 Weighted Score	**N/A**	**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	PM		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**N/A**	**50**		
Element 7 Weighted Score	**N/A**	**N/A**	**10.0**		
Element 8. Sustainability (20% weight)					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 6 Topic: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	N	N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**42.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**65.4%**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during the PIP Year 2 Findings Phase).

AGNJ Care Management Audits

AGNJ 2020 (MY 2019) Core Medicaid Care Management Audit

Determination by Category	DDD	DCP&P
	2019 (n=41)	2019 (n=89)
Outreach	98%	98%
Preventive Services	80%	84%
Continuity of Care	80%	84%
Coordination of Services	100%	99%

AGNJ 2020 Summary of Findings for Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Amerigroup	30	25	5	83%

AGNJ MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020

Performance Measure	Group[1]	July 2019 – February 2020		
		D	N	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	17	4	23.5%
	Group D	73	21	28.8%
	Group E			
	Total	90	25	27.8%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	21	21	100.0%
	Total	21	21	100.0%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	0	0	N/A
	Group D	1	1	100.0%
	Group E	2	0	0.0%
	Total	3	1	33.3%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	14	13	92.9%
	Group D	51	49	96.1%
	Group E	21	21	100.0%
	Total	86	83	96.5%
#11. Plans of Care developed using "person-centered principles" [6]	Group C	14	7	50.0%
	Group D	51	7	13.7%
	Group E	35	33	94.3%
	Total	100	47	47.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	9	1	11.1%
	Group D	50	9	18.0%
	Group E	27	12	44.4%
	Total	86	22	25.6%
#16. Member training on identifying/reporting critical incidents	Group C	14	13	92.9%
	Group D	51	50	98.0%
	Group E	35	35	100.0%
	Total	100	98	98.0%

[1]Group C is made up of members new to managed care and newly eligible to MLTSS. Group D is made up of current members newly enrolled to MLTSS. Group E is made up of members enrolled in the MCO and MLTSS prior to the review period.

[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.

[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.

[4]Members who did not have a documented change in condition during the study period are excluded from this measure.

[5]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[6]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

AGNJ MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020 – Results by Category

Determination by Category	Group C	Group D	Group E[1]	Combined[2]
Assessment	100.0%	78.4%	92.6%	81.5%
Outreach	85.7%	80.4%		81.5%
Face-to-Face Visits	50.0%	49.5%	49.6%	49.6%
Initial Plan of Care (Including Back-up Plans)	69.6%	66.4%	92.7%	75.6%
Ongoing Care Management	78.1%	82.8%	51.9%	74.0%
Gaps in Care/Critical Incidents	95.7%	99.0%	100.0%	98.9%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.
[2]Calculated as an aggregate score by combining elements applicable to each category.

AGNJ 2020 Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Amerigroup	10	9	1	90%

AGNJ 2020 Nursing Facility Audit

Due to the COVID-19 Pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2020 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	11	10	8	12	2	0	86%	2	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	19	16	10	10	19	0	0	100%	0	2	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	4	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	29	14	12	28	2	0	93%	0	1	2
Administration and Operations	13	13	3	3	13	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**196**	**188**	**83**	**79**	**192**	**4**	**0**	**98%**	**2**	**4**	**2**

[1] All existing elements were subject to review in the previous review period. The Care Management and Continuity of Care category was removed from the 2020 AA and scored and reviewed independently of the AA.

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

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

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

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

HNJH Performance Measures

HNJH HEDIS 2020 (MY 2019) Restated Performance Measures

Horizon showed a significant increase in their eligible population in Follow-Up After Emergency Department Visit for Mental Illness (FUM) in HEDIS 2020 (MY 2019). In MY 2019 the behavioral health benefit from the MCO was expanded to include all Medicaid members. It was identified that the significant increase was due to an issue with Horizon's vendor, Inovalon, with regard to the handling of FFS claims. HNJH ran the measures after the 2020 HEDIS submission date. IPRO reviewed and validated these measures .

The restated rates are indicated below:

HEDIS 2020 (MY 2019) Restated Measures	HNJH Rate	Status
Follow-Up After Emergency Department Visit for Mental Illness (FUM)		
6-17 years - 30-Day Follow-Up	74.01%	R
6-17 years - 7-Day Follow-Up	65.74%	R
18-64 years - 30-Day Follow-Up	63.73%	R
18-64 years - 7-Day Follow-Up	55.65%	R
65+ years - 30-Day Follow-Up	NA	R
65+ years - 7-Day Follow-Up	NA	R
Total - 30 Day Follow-Up	68.52%	R
Total - 7 Day Follow-Up	60.34%	R

HNJH Performance Improvement Projects

HNJH PIP 1: Developmental Screening and Early Intervention in Young Children

Horizon NJ Health (HNJH) **PIP 1 Topic: Developmental Screening and Early Intervention in Young Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M	M	
1b. Impacts the maximum proportion of members that is feasible		M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M	M	
1d. Reflects high-volume or high risk-conditions		M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M	M	
Element 1 Overall Review Determination		**M**	**M**	**M**	
Element 1 Overall Score		**100.0**	**100.0**	**100**	
Element 1 Weighted Score		**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	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M	M	
2c. Objectives align aim and goals with interventions		M	M	M	
Element 2 Overall Review Determination		**M**	**M**	**M**	
Element 2 Overall Score		**100.0**	**100.0**	**100**	
Element 2 Weighted Score		**5.0**	**5.0**	**5.0**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M	M	
3b. Performance indicators are measured consistently over time		M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		PM	PM	PM	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound		N/A	M	M	

Horizon NJ Health (HNJH) **PIP 1 Topic: Developmental Screening and Early Intervention in Young Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M	M	
Element 3 Overall Review Determination		**PM**	**PM**	**PM**	
Element 3 Overall Score		**50.0**	**50.0**	**50.0**	
Element 3 Weighted Score		**7.5**	**7.5**	**7.5**	
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	
4c. Provider input at focus groups and/or Quality Meetings		M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M	M	
4f. Literature review		M	M	M	
Element 4 Overall Review Determination		**M**	**M**	**M**	
Element 4 Overall Score		**100.0**	**100.0**	**100**	
Element 4 Weighted Score		**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	N/A	
5b. Actions that target member, provider and MCO		M	M	N/A	
5c. New or enhanced, starting after baseline year		M	M	N/A	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M	N/A	
Element 5 Overall Review Determination		**M**	**M**	**N/A**	
Element 5 Overall Score		**100.0**	**100.0**	**N/A**	
Element 5 Weighted Score		**15.0**	**15.0**	**N/A**	
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					

Horizon NJ Health (HNJH) **PIP 1 Topic: Developmental Screening and Early Intervention in Young Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M	M	
Element 6 Overall Review Determination		**M**	**M**	**M**	
Element 6 Overall Score		**100.0**	**100.0**	**100**	
Element 6 Weighted Score		**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	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M	M	
7d. Lessons learned & follow-up activities planned as a result		M	M	M	
Element 7 Overall Review Determination		**M**	**M**	**M**	
Element 7 Overall Score		**100.0**	**100.0**	**100**	
Element 7 Weighted Score		**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	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A	M	
Element 8 Overall Review Determination		**N/A**	**N/A**	**M**	
Element 8 Overall Score		**N/A**	**N/A**	**100**	
Element 8 Weighted Score		**N/A**	**N/A**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y	Y	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**N/A**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**77.5**	**N/A**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**91.2%**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components.
[2] Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

HNJH PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

Horizon NJ Health (HNJH) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100.0**	**100**		
Element 1 Weighted Score	**N/A**	**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		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		
Element 2 Weighted Score	**N/A**	**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)					

Horizon NJ Health (HNJH) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100.0**	**100**		
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data (“5 Why’s”, fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		

Horizon NJ Health (HNJH) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 4 Overall Score	**N/A**	**100.0**	**100**		
Element 4 Weighted Score	**N/A**	**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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	N/A		
Element 5 Overall Review Determination	**N/A**	**M**	**N/A**		
Element 5 Overall Score	**N/A**	**100.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**15.0**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100.0**	**100**		
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A	M		

Horizon NJ Health (HNJH) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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**	**N/A**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**		
Element 7 Weighted Score	**N/A**	**N/A**	**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		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**100%**	**100%**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

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

HNJH PIP 3: Increasing PCP Access and Availability for Members with low acuity, non-emergent ED visits

Horizon NJ Health (HNJH) **PIP 3 Topic: Increasing PCP Access and Availability for Members with low acuity, non-emergent ED visits**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	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					
1b. Impacts the maximum proportion of members that is feasible					
1c. Potential for meaningful impact on member health, functional status or satisfaction					
1d. Reflects high-volume or high risk-conditions					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)					
Element 1 Overall Review Determination	**N/A**				
Element 1 Overall Score	**N/A**				
Element 1 Weighted Score	**N/A**				
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark					
2c. Objectives align aim and goals with interventions					
Element 2 Overall Review Determination	**N/A**				
Element 2 Overall Score	**N/A**				
Element 2 Weighted Score	**N/A**				
Element 3. Methodology Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)					
3b. Performance indicators are measured consistently over time					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]					
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.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline					

Horizon NJ Health (HNJH) **PIP 3 Topic: Increasing PCP Access and Availability for Members with low acuity, non-emergent ED visits**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3h. Study design specifies data analysis procedures with a corresponding timeline					
Element 3 Overall Review Determination	**N/A**				
Element 3 Overall Score	**N/A**				
Element 3 Weighted Score	**N/A**				
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach					
4c. Provider input at focus groups and/or Quality Meetings					
4d. QI Process data ("5 Why's", fishbone diagram)					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)					
4f. Literature review					
Element 4 Overall Review Determination	**N/A**				
Element 4 Overall Score	**N/A**				
Element 4 Weighted Score	**N/A**				
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis					
5b. Actions that target member, provider and MCO					
5c. New or enhanced, starting after baseline year					
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)					
Element 5 Overall Review Determination	**N/A**				
Element 5 Overall Score	**N/A**				
Element 5 Weighted Score	**N/A**				
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals					
Element 6 Overall Review Determination	**N/A**				
Element 6 Overall Score	**N/A**				

Horizon NJ Health (HNJH) **PIP 3 Topic: Increasing PCP Access and Availability for Members with low acuity, non-emergent ED visits**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 6 Weighted Score	**N/A**				
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.					
7d. Lessons learned & follow-up activities planned as a result					
Element 7 Overall Review Determination	**N/A**				
Element 7 Overall Score	**N/A**				
Element 7 Weighted Score	**N/A**				
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**				
Element 8 Overall Score	**N/A**				
Element 8 Weighted Score	**N/A**				
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed	N				
	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

[1]Proposal Findings were not scored.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

HNJH PIP 4: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population

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

Horizon NJ Health (HNJH) **PIP 4 Topic: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
(IRR)]					
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**		
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**		
Element 4 Weighted Score	**N/A**	**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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	N/A		
Element 5 Overall Review Determination	**N/A**	**M**	**N/A**		

Horizon NJ Health (HNJH) **PIP 4 Topic: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 5 Overall Score	**N/A**	**100**	**N/A**		
Element 5 Weighted Score	**N/A**	**15.0**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**		
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A	M		
7d. Lessons learned & follow-up activities planned as a result		N/A	M		
Element 7 Overall Review Determination	**N/A**	**N/A**	**PM**		
Element 7 Overall Score	**N/A**	**0**	**50**		
Element 7 Weighted Score	**N/A**	**0.0**	**10.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	N	N	N		

Horizon NJ Health (HNJH) PIP 4 Topic: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting population	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**60.0**	**55.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**100.0%**	**84.6%**	**N/A**	**N/A**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Proposal Findings were not scored.
[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Year 2 Findings Phase).

HNJH Care Management Audits

HNJH 2020 (MY 2019) Core Medicaid Care Management Audit

Determination by Category	DDD	DCP&P
	2019 (n=68)	2019 (n=100)
Outreach	99%	99%
Preventive Services	77%	91%
Continuity of Care	79%	90%
Coordination of Services	99%	100%

HNJH 2020 Summary of Findings for Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Horizon	30	25	5	83%

HNJH MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020

Performance Measure	Group[1]	July 2019 – February 2020		
		D	N	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	34	33	97.1%
	Group D	54	51	94.4%
	Group E			
	Total	88	84	95.5%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	24	24	100.0%
	Total	24	24	100.0%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	0	0	N/A
	Group D	1	1	100.0%
	Group E	1	0	0.0%
	Total	2	1	50.0%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	22	22	100.0%
	Group D	43	43	100.0%
	Group E	24	24	100.0%
	Total	89	89	100.0%
#11. Plans of Care developed using "person-centered principles" [6]	Group C	22	21	95.5%
	Group D	43	43	100.0%
	Group E	35	35	100.0%
	Total	100	99	99.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	14	13	92.9%
	Group D	42	42	100.0%
	Group E	32	25	78.1%
	Total	88	80	90.9%
#16. Member training on identifying/reporting critical incidents	Group C	22	22	100.0%
	Group D	43	43	100.0%
	Group E	35	35	100.0%
	Total	100	100	100.0%

[1]Group C is made up of members new to managed care and newly eligible to MLTSS. Group D is made up of current members newly enrolled to MLTSS. Group E is made up of members enrolled in the MCO and MLTSS prior to the review period.
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[4]Members who did not have a documented change in condition during the study period are excluded from this measure.
[5]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[6]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

HNJH MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020 – Results by Category

Determination by Category	Group C	Group D	Group E[1]	Combined[2]
Assessment	100.0%	92.4%	100.0%	94.4%
Outreach	86.4%	74.4%		78.5%
Face-to-Face Visits	87.3%	98.3%	83.5%	91.1%
Initial Plan of Care (Including Back-up Plans)	97.7%	98.7%	94.2%	96.9%
Ongoing Care Management	89.8%	89.9%	72.0%	85.2%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.
[2]Calculated as an aggregate score by combining elements applicable to each category.

HNJH 2020 Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
Horizon	10	10	0	100%

HNJH 2020 Nursing Facility Audit

Due to the COVID-19 Pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2020 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	10	10	6	10	4	0	71%	4	0	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	19	14	12	11	18	1	0	95%	1	3	0
Efforts to Reduce Healthcare Disparities	5	4	5	4	4	1	0	80%	1	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	43	12	8	40	4	0	91%	0	1	4
Provider Training and Performance	11	10	5	5	11	0	0	100%	0	1	0
Satisfaction	5	4	3	3	5	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	3	7	1	0	88%	0	0	1
Credentialing and Recredentialing	10	9	4	2	8	2	0	80%	1	0	1
Utilization Management	30	22	14	11	27	1	2	96%	1	5	0
Administration and Operations	13	12	3	3	13	0	0	100%	0	1	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**196**	**173**	**88**	**72**	**180**	**14**	**2**	**93%**	**8**	**11**	**6**

[1] All existing elements were subject to review in the previous review period. The Care Management and Continuity of Care category was removed from the 2020 AA and scored and reviewed independently of the AA.

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

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

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

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

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UHCCP Performance Improvement Projects

UHCCP PIP 1: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)

UnitedHealthcare Community Plan (UHCCP) **PIP 1 Topic: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M	M	
1b. Impacts the maximum proportion of members that is feasible		M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M	M	
1d. Reflects high-volume or high risk-conditions		M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M	M	
Element 1 Overall Review Determination		**M**	**M**	**M**	
Element 1 Overall Score		**100.0**	**100.0**	**100**	
Element 1 Weighted Score		**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	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M	M	
2c. Objectives align aim and goals with interventions		PM	M	M	
Element 2 Overall Review Determination		**PM**	**M**	**M**	
Element 2 Overall Score		**50.0**	**100.0**	**100**	
Element 2 Weighted Score		**2.5**	**5.0**	**5.0**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	PM	M	
3b. Performance indicators are measured consistently over time		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	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M	M	

UnitedHealthcare Community Plan (UHCCP) PIP 1 Topic: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
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		M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M	M	
Element 3 Overall Review Determination		**M**	**PM**	**M**	
Element 3 Overall Score		**100.0**	**50.0**	**100**	
Element 3 Weighted Score		**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	N/A	N/A	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	
4c. Provider input at focus groups and/or Quality Meetings		M	N/A	N/A	
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	N/A	N/A	
4f. Literature review		M	N/A	N/A	
Element 4 Overall Review Determination		**M**	**M**	**M**	
Element 4 Overall Score		**100.0**	**100.0**	**100**	
Element 4 Weighted Score		**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	N/A	
5b. Actions that target member, provider and MCO		PM	M	N/A	
5c. New or enhanced, starting after baseline year		PM	M	N/A	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M	N/A	
Element 5 Overall Review Determination		**PM**	**M**	**N/A**	
Element 5 Overall Score		**50.0**	**100.0**	**N/A**	
Element 5 Weighted Score		**7.5**	**15.0**	**N/A**	

UnitedHealthcare Community Plan (UHCCP) **PIP 1 Topic: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M	M	
Element 6 Overall Review Determination		**M**	**M**	**M**	
Element 6 Overall Score		**100.0**	**100.0**	**100**	
Element 6 Weighted Score		**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	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M	M	
7d. Lessons learned & follow-up activities planned as a result		PM	M	M	
Element 7 Overall Review Determination		**PM**	**M**	**M**	
Element 7 Overall Score		**50.0**	**100.0**	**100**	
Element 7 Weighted Score		**10.0**	**20.0**	**20.0**	
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A	M	
Element 8 Overall Review Determination		**N/A**	**N/A**	**M**	
Element 8 Overall Score		**N/A**	**N/A**	**100**	
Element 8 Weighted Score		**N/A**	**N/A**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		Y	Y	Y	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**N/A**

UnitedHealthcare Community Plan (UHCCP) PIP 1 Topic: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Actual Weighted Total Score	**N/A**	**60.0**	**72.5**	**85.0**	**N/A**
Overall Rating	**N/A**	**75.0%**	**90.6%**	**100%**	**N/A**

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

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

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

UHCCP PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

UnitedHealthcare Community Plan (UHCCP) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100.0**	**100**		
Element 1 Weighted Score	**N/A**	**5.0**	**5**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		
Element 2 Weighted Score	**N/A**	**5.0**	**5**		

UnitedHealthcare Community Plan (UHCCP) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50.0**	**100**		
Element 3 Weighted Score	**N/A**	**7.5**	**15**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100.0**	**100**		
Element 4 Weighted Score	**N/A**	**15.0**	**15**		
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.					

UnitedHealthcare Community Plan (UHCCP) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
5a. Informed by barrier analysis		M	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100.0**	**100**		
Element 6 Weighted Score	**N/A**	**5.0**	**5**		
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**	**N/A**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**		
Element 7 Weighted Score	**N/A**	**N/A**	**20**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		

UnitedHealthcare Community Plan (UHCCP) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	N/A	N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**45.0**	**65.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**75.0%**	**100%**	**N/A**	**N/A**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Proposal Findings were not scored.
[2]Due to COVID-19 impacting interventions, Element 5 is not scored in 2020 (during this PIP's Sustainability Phase).

UHCCP PIP 3: Decrease Emergency Room Utilization

UnitedHealthcare Community Plan (UHCCP) PIP 3 Topic: Decrease Emergency Room Utilization	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	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					
1b. Impacts the maximum proportion of members that is feasible					
1c. Potential for meaningful impact on member health, functional status or satisfaction					
1d. Reflects high-volume or high risk-conditions					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)					
Element 1 Overall Review Determination	**N/A**				
Element 1 Overall Score	**N/A**				
Element 1 Weighted Score	**N/A**				
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					

UnitedHealthcare Community Plan (UHCCP) **PIP 3 Topic: Decrease Emergency Room Utilization**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
2a. Aim specifies Performance Indicators for improvement with corresponding goals					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark					
2c. Objectives align aim and goals with interventions					
Element 2 Overall Review Determination	**N/A**				
Element 2 Overall Score	**N/A**				
Element 2 Weighted Score	**N/A**				
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)					
3b. Performance indicators are measured consistently over time					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]					
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.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline					
3h. Study design specifies data analysis procedures with a corresponding timeline					
Element 3 Overall Review Determination	**N/A**				
Element 3 Overall Score	**N/A**				
Element 3 Weighted Score	**N/A**				
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach					
4c. Provider input at focus groups and/or Quality Meetings					
4d. QI Process data (“5 Why’s”, fishbone diagram)					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)					

UnitedHealthcare Community Plan (UHCCP) PIP 3 Topic: Decrease Emergency Room Utilization	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
4f. Literature review					
Element 4 Overall Review Determination	**N/A**				
Element 4 Overall Score	**N/A**				
Element 4 Weighted Score	**N/A**				
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis					
5b. Actions that target member, provider and MCO					
5c. New or enhanced, starting after baseline year					
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)					
Element 5 Overall Review Determination	**N/A**				
Element 5 Overall Score	**N/A**				
Element 5 Weighted Score	**N/A**				
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals					
Element 6 Overall Review Determination	**N/A**				
Element 6 Overall Score	**N/A**				
Element 6 Weighted Score	**N/A**				
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.					
7d. Lessons learned & follow-up activities planned as a result					
Element 7 Overall Review Determination	**N/A**				
Element 7 Overall Score	**N/A**				
Element 7 Weighted Score	**N/A**				
Element 8. Sustainability (20% weight)					

UnitedHealthcare Community Plan (UHCCP) **PIP 3 Topic: Decrease Emergency Room Utilization**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
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					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**				
Element 8 Overall Score	**N/A**				
Element 8 Weighted Score	**N/A**				
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N				
	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)
[1]Proposal Findings were not scored.

UHCCP PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population

UnitedHealthcare Community Plan (UHCCP) **PIP 4 Topic: Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	PM		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		

UnitedHealthcare Community Plan (UHCCP) PIP 4 Topic: Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**PM**		
Element 1 Overall Score	**N/A**	**100.0**	**50**		
Element 1 Weighted Score	**N/A**	**5.0**	**2.5**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	PM		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		PM	M		
Element 2 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 2 Overall Score	**N/A**	**50.0**	**50**		
Element 2 Weighted Score	**N/A**	**2.5**	**2.5**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	PM		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		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		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M	PM		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**PM**		
Element 3 Overall Score	**N/A**	**100.0**	**50**		
Element 3 Weighted Score	**N/A**	**15.0**	**7.5**		

UnitedHealthcare Community Plan (UHCCP) **PIP 4 Topic: Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100.0**	**100**		
Element 4 Weighted Score	**N/A**	**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	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM	M		
Element 6 Overall Review Determination	**N/A**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**50.0**	**100**		
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report					

UnitedHealthcare Community Plan (UHCCP) **PIP 4 Topic: Improving Influenza and Pneumococcal Immunization Rates in the MLTSS Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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**	**N/A**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**		
Element 7 Weighted Score	**N/A**	**N/A**	**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		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**47.5**	**52.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**79.2%**	**80.8%**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

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

UHCCP Care Management Audits

UHCCP 2020 (MY 2019) Core Medicaid Care Management Audit

Determination by Category	DDD	DCP&P
	2019 (n=53)	2019 (n=100)
Outreach	100%	97%
Preventive Services	73%	83%
Continuity of Care	78%	95%
Coordination of Services	98%	100%

UHCCP 2020 Summary of Findings for Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
United	30	25	5	83%

UHCCP MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020

Performance Measure	Group[1]	July 2019 – February 2020		
		D	N	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	46	20	43.5%
	Group D	45	25	55.6%
	Group E			
	Total	91	45	49.5%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	22	22	100.0%
	Total	22	22	100.0%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	1	1	100.0%
	Group D	0	0	N/A
	Group E	0	0	N/A
	Total	1	1	100.0%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	31	28	90.3%
	Group D	35	34	97.1%
	Group E	23	22	95.7%
	Total	89	84	94.4%
#11. Plans of Care developed using "person-centered principles" [6]	Group C	31	11	35.5%
	Group D	35	4	11.4%
	Group E	34	19	55.9%
	Total	100	34	34.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	20	18	90.0%
	Group D	35	32	91.4%
	Group E	30	22	73.3%
	Total	85	72	84.7%
#16. Member training on identifying/reporting critical incidents	Group C	31	25	80.6%
	Group D	35	34	97.1%
	Group E	34	33	97.1%
	Total	100	92	92.0%

[1]Group C is made up of members new to managed care and newly eligible to MLTSS. Group D is made up of current members newly enrolled to MLTSS. Group E is made up of members enrolled in the MCO and MLTSS prior to the review period.
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[4]Members who did not have a documented change in condition during the study period are excluded from this measure.
[5]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[6]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

UHCCP MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020 – Results by Category

Determination by Category	Group C	Group D	Group E[1]	Combined[2]
Assessment	100.0%	69.6%	91.2%	77.9%
Outreach	71.0%	65.7%		68.2%
Face-to-Face Visits	69.7%	71.5%	74.4%	71.9%
Initial Plan of Care (Including Back-up Plans)	75.8%	80.8%	87.9%	81.8%
Ongoing Care Management	77.9%	79.8%	53.3%	72.8%
Gaps in Care/Critical Incidents	86.3%	95.8%	93.9%	92.6%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.
[2]Calculated as an aggregate score by combining elements applicable to each category.

UHCCP 2020 Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
United	10	9	1	90%

UHCCP 2020 Nursing Facility Audit

Due to the COVID-19 Pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.

WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

WCHP 2020 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	8	10	8	12	2	0	86%	1	5	1
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	19	17	10	10	19	0	0	100%	0	1	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	11	11	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	5	4	3	2	4	1	0	80%	0	0	1
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	30	14	12	28	2	0	93%	0	0	2
Administration and Operations	13	13	3	3	13	0	0	100%	0	0	0
Management Information Systems	18	18	3	3	18	0	0	100%	0	0	0
TOTAL	**196**	**187**	**83**	**78**	**191**	**5**	**0**	**97%**	**1**	**6**	**4**

[1] A total of 94 elements were reviewed in the previous review period; of these 94, 87 were *Met* and 7 were *Not Met*. Remaining existing elements (131) that were *Met Prior Year* were deemed *Met* in the previous review period. The Care Management and Continuity of Care category was removed from the 2020 AA and scored and reviewed independently of the AA.

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

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

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

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

WCHP Performance Improvement Projects

WCHP PIP 1: Improving the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 1 Topic: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M	M	
1b. Impacts the maximum proportion of members that is feasible		M	M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M	M	
1d. Reflects high-volume or high risk-conditions		M	M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M	M	
Element 1 Overall Review Determination		**M**	**M**	**M**	
Element 1 Overall Score		**100.0**	**100.0**	**100**	
Element 1 Weighted Score		**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	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M	M	
2c. Objectives align aim and goals with interventions		M	M	M	
Element 2 Overall Review Determination		**M**	**M**	**M**	
Element 2 Overall Score		**100.0**	**100.0**	**100**	
Element 2 Weighted Score		**5.0**	**5.0**	**5.0**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M	M	
3b. Performance indicators are measured consistently over time		M	M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		PM	M	M	
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM	M	M	

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 1 Topic: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		N/A	M	N/A	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M	M	
Element 3 Overall Review Determination		**PM**	**M**	**M**	
Element 3 Overall Score		**50.0**	**100.0**	**100**	
Element 3 Weighted Score		**7.5**	**15.0**	**15.0**	
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M	M	
4c. Provider input at focus groups and/or Quality Meetings		M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)		M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M	M	
4f. Literature review		M	M	M	
Element 4 Overall Review Determination		**M**	**M**	**M**	
Element 4 Overall Score		**100.0**	**100.0**	**100**	
Element 4 Weighted Score		**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	N/A	
5b. Actions that target member, provider and MCO		M	M	N/A	
5c. New or enhanced, starting after baseline year		M	M	N/A	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M	N/A	
Element 5 Overall Review Determination		**M**	**M**	**N/A**	
Element 5 Overall Score		**100.0**	**100.0**	**N/A**	
Element 5 Weighted Score		**15.0**	**15.0**	**N/A**	

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 1 Topic: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M	M	
Element 6 Overall Review Determination		**M**	**M**	**M**	
Element 6 Overall Score		**100.0**	**100.0**	**100**	
Element 6 Weighted Score		**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	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M	PM	
7d. Lessons learned & follow-up activities planned as a result		M	M	M	
Element 7 Overall Review Determination		**M**	**M**	**PM**	
Element 7 Overall Score		**100.0**	**100.0**	**50.0**	
Element 7 Weighted Score		**20.0**	**20.0**	**10.0**	
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A	M	
Element 8 Overall Review Determination		**N/A**	**N/A**	**M**	
Element 8 Overall Score		**N/A**	**N/A**	**100**	
Element 8 Weighted Score		**N/A**	**N/A**	**20.0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y	Y	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**85.0**	**N/A**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**75.0**	**N/A**

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 1 Topic: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings[2]	Final Report Findings
Overall Rating	**N/A**	**90.6%**	**100.0%**	**88.2%**	**N/A**

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

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

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

WCHP PIP 2: MCO Adolescent Risk Behaviors and Depression Collaborative

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100.0**	**100**		
Element 1 Weighted Score	**N/A**	**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		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100.0**	**100**		
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**		

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100.0**	**100**		
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	PM		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**PM**		
Element 4 Overall Score	**N/A**	**100.0**	**50**		
Element 4 Weighted Score	**N/A**	**15.0**	**7.5**		
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5,					

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	N/A		
5b. Actions that target member, provider and MCO		M	N/A		
5c. New or enhanced, starting after baseline year		M	N/A		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	N/A		
Element 5 Overall Review Determination	**N/A**	**PM**	**N/A**		
Element 5 Overall Score	**N/A**	**50.0**	**N/A**		
Element 5 Weighted Score	**N/A**	**7.5**	**N/A**		
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100.0**	**100**		
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A	M		
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**	**N/A**	**M**		
Element 7 Overall Score	**N/A**	**N/A**	**100**		
Element 7 Weighted Score	**N/A**	**N/A**	**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		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 2 Topic: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**52.5**	**57.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**87.5%**	**88.5%**	**N/A**	**N/A**

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

[1] Proposal Findings were not scored

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

WCHP PIP 3: Medicaid Primary Care Physician Access and Availability

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3 Topic: Medicaid Primary Care Physician Access and Availability	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	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					
1b. Impacts the maximum proportion of members that is feasible					
1c. Potential for meaningful impact on member health, functional status or satisfaction					
1d. Reflects high-volume or high risk-conditions					
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)					
Element 1 Overall Review Determination	**N/A**				
Element 1 Overall Score	**N/A**				
Element 1 Weighted Score	**N/A**				

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3 Topic: Medicaid Primary Care Physician Access and Availability	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
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					
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark					
2c. Objectives align aim and goals with interventions					
Element 2 Overall Review Determination	**N/A**				
Element 2 Overall Score	**N/A**				
Element 2 Weighted Score	**N/A**				
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)					
3b. Performance indicators are measured consistently over time					
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes					
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined					
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]					
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.					
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline					
3h. Study design specifies data analysis procedures with a corresponding timeline					
Element 3 Overall Review Determination	**N/A**				
Element 3 Overall Score	**N/A**				
Element 3 Weighted Score	**N/A**				
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics					
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach					
4c. Provider input at focus groups and/or Quality Meetings					

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 3 Topic: Medicaid Primary Care Physician Access and Availability**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
4d. QI Process data ("5 Why's", fishbone diagram)					
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)					
4f. Literature review					
Element 4 Overall Review Determination	**N/A**				
Element 4 Overall Score	**N/A**				
Element 4 Weighted Score	**N/A**				
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis					
5b. Actions that target member, provider and MCO					
5c. New or enhanced, starting after baseline year					
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)					
Element 5 Overall Review Determination	**N/A**				
Element 5 Overall Score	**N/A**				
Element 5 Weighted Score	**N/A**				
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals					
Element 6 Overall Review Determination	**N/A**				
Element 6 Overall Score	**N/A**				
Element 6 Weighted Score	**N/A**				
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)					
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan					
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.					
7d. Lessons learned & follow-up activities planned as a result					
Element 7 Overall Review Determination	**N/A**				
Element 7 Overall Score	**N/A**				

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3 Topic: Medicaid Primary Care Physician Access and Availability	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Weighted Score	**N/A**				
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	**N/A**				
Element 8 Overall Score	**N/A**				
Element 8 Weighted Score	**N/A**				
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (**Y**=Yes **N**=No)	N				
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

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

[1] Proposal Findings were not scored.

WCHP PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 4 Topic: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 4 Topic: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination	**N/A**	**M**	**M**		
Element 1 Overall Score	**N/A**	**100**	**100**		
Element 1 Weighted Score	**N/A**	**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		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination	**N/A**	**M**	**M**		
Element 2 Overall Score	**N/A**	**100**	**100**		
Element 2 Weighted Score	**N/A**	**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		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		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
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		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**		
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**		

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 4 Topic: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**		
Element 4 Weighted Score	**N/A**	**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	NA		
5b. Actions that target member, provider and MCO		M	NA		
5c. New or enhanced, starting after baseline year		M	NA		
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	NA		
Element 5 Overall Review Determination	**N/A**	**PM**	**NA**		
Element 5 Overall Score	**N/A**	**50**	**NA**		
Element 5 Weighted Score	**N/A**	**7.5**	**NA**		
Element 6. Results Table (15% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination	**N/A**	**M**	**M**		
Element 6 Overall Score	**N/A**	**100**	**100**		
Element 6 Weighted Score	**N/A**	**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.					

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 4 Topic: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings[2]	Sustainability Findings	Final Report Findings
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**	**N/A**	**M**		
Element 7 Overall Score	**N/A**	**0**	**100**		
Element 7 Weighted Score	**N/A**	**0.0**	**20.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**		
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	N	N	N		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**55.0**	**60.0**	**65.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**52.5**	**65.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**87.5%**	**100%**	**N/A**	**N/A**

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

[1] Proposal Findings were not scored.

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

WCHP Care Management Audits

WCHP 2020 (MY 2019) Core Medicaid Care Management Audit

Determination by Category	DDD	DCP&P
	2019 (n=43)	2019 (n=21)
Outreach	99%	93%
Preventive Services	73%	75%
Continuity of Care	74%	81%
Coordination of Services	99%	100%

WCHP 2020 Summary of Findings for Core Medicaid Care Management and Continuity of Care Standard

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
WellCare	30	27	3	90%

WCHP MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020

Performance Measure	Group[1]	July 2019 – February 2020		
		D	N	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[2]	Group C	13	7	53.8%
	Group D	77	55	71.4%
	Group E			
	Total	90	62	68.9%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[3]	Group C			
	Group D			
	Group E	21	18	85.7%
	Total	21	18	85.7%
#9a. Member's Plan of Care is amended based on change of member condition[4]	Group C	0	0	N/A
	Group D	0	0	N/A
	Group E	0	0	N/A
	Total	0	0	N/A
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[5]	Group C	10	9	90.0%
	Group D	55	53	96.4%
	Group E	24	23	95.8%
	Total	89	85	95.5%
#11. Plans of Care developed using "person-centered principles" [6]	Group C	10	9	90.0%
	Group D	55	49	89.1%
	Group E	35	24	68.6%
	Total	100	82	82.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[7]	Group C	9	7	77.8%
	Group D	54	48	88.9%
	Group E	35	34	97.1%
	Total	98	89	90.8%
#16. Member training on identifying/reporting critical incidents	Group C	10	9	90.0%
	Group D	55	54	98.2%
	Group E	35	34	97.1%
	Total	100	97	97.0%

[1]Group C is made up of members new to managed care and newly eligible to MLTSS. Group D is made up of current members newly enrolled to MLTSS. Group E is made up of members enrolled in the MCO and MLTSS prior to the review period.
[2]Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.
[3]For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.
[4]Members who did not have a documented change in condition during the study period are excluded from this measure.
[5]Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[6]In the current review period, documentation should have demonstrated that the member and/or authorized representative were involved in goal setting and in agreement with the established goals. The member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.
[7]Members in CARS are excluded from this measure.
CNC: Could not calculate; N/A: Not applicable

WCHP MLTSS HCBS Care Management Audit – July 1, 2019 – February 29, 2020 – Results by Category

Determination by Category	Group C	Group D	Group E[1]	Combined[2]
Assessment	100.0%	65.6%	88.9%	70.4%
Outreach	90.0%	85.5%		86.2%
Face-to-Face Visits	79.1%	93.8%	80.2%	87.8%
Initial Plan of Care (Including Back-up Plans)	78.9%	88.1%	90.2%	88.0%
Ongoing Care Management	74.1%	77.8%	59.7%	72.4%
Gaps in Care/Critical Incidents	89.5%	98.2%	97.1%	97.0%

[1]Initial outreach is not assessed for members in Group E because Group E members are not new to MLTSS.
[2]Calculated as an aggregate score by combining elements applicable to each category.

WCHP 2020 Results Summary of Findings for MLTSS Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
WellCare	10	10	0	100%

WCHP 2020 Nursing Facility Audit

Due to the COVID-19 Pandemic, it was mutually agreed upon by DMAHS and IPRO that the Nursing Facility Care Management Audit for 2020 would be postponed until the following contract year.