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New Jersey Department of Human Services
Division of Medical Assistance and Health Services
CORE MEDICAID and MLTSS
External Quality Review
Annual Technical Report
Review Period: January 1, 2025–December 31, 2025
(2025–2026 Reporting Cycle)

ipro.org

Per *Title 42 CFR § 438.364(a)(7),* no managed care organization was exempt from the external quality review activities conducted in CY 2025.

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Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), contracted with IPRO, an EQRO, to conduct the 2025 EQR activities (reporting cycle 2025–2026) for five MCOs contracted to furnish Medicaid services in the State. DMAHS's participating NJ FamilyCare MCOs included Aetna Better Health of New Jersey (ABHNJ), Fidelis Care (FC/WCHP), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and Wellpoint New Jersey, Inc. (WPNJ). No MCOs were exempt from EQR activities conducted in calendar year (CY) 2025. As per DMAHS, enrollment in ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ for the Core Medicaid and Managed Long-Term Services and Supports (MLTSS) Programs was 1,732,376 as of 12/31/2025. This report presents aggregate and MCO-level results of these EQR activities for ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ.

Scope of External Quality Review Activities Conducted

This EQR annual technical report (ATR) focuses on the four mandatory and five optional EQR activities that were conducted. EQR activities conducted from January 2025–December 2025 included validation of performance improvement projects (PIPs), performance measure (PM) validation, Annual Assessment of MCO operations, network adequacy, as well as focus studies, which include Core Medicaid care management (CM) audits, and MLTSS CM audits, encounter data validation (EDV) ongoing monitoring, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and calculation of additional PMs. It should be noted that the protocols for this year were based on the February 2023 CMS *External Quality Review (EQR) Protocols.*

The updated protocols stated that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1–4, and an optional component under Protocols 5–9, as well as part of the EQR Annual Technical Report." As set forth in *Title 42 CFR § 438.358 Activities related to external quality review* (b)(1), these activities are:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Mandatory Protocol 4:* Validation of Network Adequacy -** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population.
- ***CMS Optional Protocol 5:* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality-of-Care Surveys –** Satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.
- ***CMS Optional Protocol 7: Calculation of Additional Performance Measures* –** One purpose of quality measurement is to evaluate the degree to which evidence-based treatment guidelines are followed, where indicated, and to assess the results of care.
- ***CMS Optional Protocol 8: Implementation of Additional Performance Improvement Projects* –** In addition, Federal regulations at 42 CFR 438.358(c)(4) and 457.1250(a) specify that the external quality review organization (EQRO) may conduct PIPs in addition to those performed by the MCOs as a part of their QAPI programs.
- ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality –** This activity conducts clinical and nonclinical focus studies to assess quality of care at a point in time.
- ***EQR Annual Technical Report (ATR)* –** Results of all EQR-related activities. CMS requires that all states have final EQR technical reports available to CMS and the public by April 30 of each year.

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

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

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

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2025–2026 EQR activity findings to assess the performance of NJ Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

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

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted from January 1, 2025, through December 31, 2025, demonstrated that DMAHS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members. The strengths, opportunities for improvement and recommendations relating to quality of, timeliness of, and access to care are outlined here and detailed in each corresponding section of this report.

Validation of Performance Improvement Projects

For January 2025–December 2025, this ATR includes IPRO's evaluation of the April 2025 PIP updates and August 2025 PIP report submissions. In addition, IPRO reviewed two PIP proposals: one for Core Medicaid on Immunizations for Adolescents (IMA), and one for MLTSS on 10-Day Post-Discharge Visit with Assessment and provided feedback and guidance to all five MCOs. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure the PIP met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Full validation results for the Core Medicaid and MLTSS 2025 are described in the **Validation of Performance Improvement Projects** section.

Core Medicaid

The following four Medicaid PIPs were conducted by the MCOs during the ATR review period. Two Core Medicaid PIPs are clinical, and two PIPs are nonclinical.

1. Access and Availability of PCP Services (Nonclinical PIP) – (ABHNJ) – (August Project Status Reports Submission – Final Report) Note: ABHNJ is one year behind in the PIP reporting cycle.
2. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) – (August Project Status Reports Submission – Final Report).
3. Member Grievances (Nonclinical PIP) – (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) – (August Project Status Reports Submission – Project Year 1 and Project Year 2 Update).
4. Immunizations for Adolescents (IMA) – (ABHNJ, HNJH, UHCCP and WPNJ) – (August Project Status Reports Submission – Baseline Report and Project Year 1 Update).

One PIP Proposal (PIP implemented in October 2025) on Immunizations for Adolescents (IMA) was developed by FC/WCHP.

MLTSS

The following two MLTSS PIPs were conducted by the MCOs during the ATR review period.

1. Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS Home and Community Based Services (HCBS) – (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) – (August – Project Status Reports Submission – Final Report).
2. Increasing the number of 10-day post-discharge visits with assessment for the MLTSS population – (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) – (August Project Status Reports Submission – Baseline Report and Project Year 1 Update).

Validation of Performance Measures

Information Systems Capabilities Assessment

Pursuant to the release of the updated EQRO Protocols by CMS in 2023, DMAHS requested IPRO to conduct an ISCA review in 2024 for all NJ MCOs. In addition to customizing the ISCA survey tool for NJ's Medicaid products, including MLTSS, the ISCA was also modified to include questions relating to the NJ Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). Additional questions were included related to the annual NJ State-specific performance measures, Healthcare Effectiveness Data and Information Set (HEDIS®) Electronic Clinical Data Systems (ECDS) measures and race and ethnicity categories and encounter data submissions to the State. Details of this assessment can be found in the **Validation of Performance Measures** section.

The MCO's information system assessment reviews included:

- Data Integration and Systems Architecture,
- Membership Data Systems and Processes,
- Claims Data Systems and Processes,
- Performance Measure Reporting,
- Race and Ethnicity and ECDS Measures,
- Provider Data Systems and Processes,
- Provider Network Adequacy,
- Oversight of Contracted Vendors,
- Grievance Systems, and
- Encounter Data Submissions to State.

Separate from the ISCA, all five MCOs undergo a systems review annually as part of their HEDIS audit by a National Committee for Quality Assurance (NCQA)-licensed organization. IPRO reviews these results annually. Details of this review can be found in the **Validation of Performance Measures** section.

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

MY 2024 New Jersey HEDIS Performance Measures

(The NCQA national Medicaid benchmarks are referenced in this section, unless stated otherwise).

The NJ FamilyCare Managed Care Contract Article 4.6.2.P requires NJ FamilyCare MCOs to report annually on HEDIS PMs. 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 on the HEDIS final audit report (FAR) prepared by an NCQA-licensed audit organization for each MCO as required by NCQA. Children's Health Insurance Program (CHIP) is included in the Medicaid data being presented.

Notable HEDIS Measure Changes from MY 2023 to MY 2024

1. For MY 2024, NCQA retired the following measures:
    a. Ambulatory Care (AMB)
2. The following measures were retired but kept their ECDS counterpart:
    a. Colorectal Cancer Screening (COL),
    b. Follow-Up Care for Children Prescribed ADHD Medication (ADD), and
    c. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM).
3. There were also overall changes to multiple value sets and specific changes per measures, including that the former Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD) was revised to Glycemic Status Assessment for Patients with Diabetes (GSD).
4. Caution flags for trending determinations were added to several measures due to changes in specific measure criteria that could affect denominator, numerator or exclusions:
    a. Glycemic Status Assessment for Patients with Diabetes (GSD)
    b. Blood Pressure Control for Patients with Diabetes (BPD)
    c. Eye Exam for Patients with Diabetes (EED)
    d. Kidney Health Evaluation for Patients with Diabetes (KED)

e. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)
f. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
g. Prenatal and Postpartum Care (PPC)
h. Prenatal Immunization Status (PRS-E)
i. Prenatal Depression Screening and Follow-Up (PND-E)
j. Postpartum Depression Screening and Follow-Up (PDS-E)
k. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

5. Break in trending for all product lines due to significant changes to the specifications of the following measures:
    a. Plan All-Cause Readmissions (PCR)

MY 2024 New Jersey State-Specific Performance Measures and Core Set Measures

DMAHS reports annually on all mandatory Child and Adult Core Set Measures. Core Set and NJ specific performance measures reported for MY 2024 that are stratified by MCO can be categorized as follows:

There was one required NJ State-Specific PM measure:
1. Multiple Lead Testing in Children through 26 months of age (MLT)

There are seven 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)
4. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
5. Oral Evaluation, Dental Services (OEV-CH)
6. Topical Fluoride for Children (TFL-CH)
7. Sealant Receipt on Permanent First Molars (SFM-CH)

There are eight Adult Core Set Measures:
1. Diabetes Short-Term Complications Admission Rate (PQI01-AD) – Admissions per 100,000 Member Months
2. Contraceptive Care Postpartum Women Ages 21-44 (CCP-AD)
3. Contraceptive Care All Women Ages 21-44 (CCW-AD)
4. Screening for Depression and Follow-Up Plan: Ages 18 to 64 and Ages 65 and older (CDF-AD)
5. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
6. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD): Ages 18 to 64
7. Concurrent Use of Opioids and Benzodiazepines (COB-AD)
8. Use of Opioids at High Dosage without Cancer (OHD-AD)

Details of these results can be found in the **Validation of Performance Measures** section.

Dual Eligible Reporting

- Wellpoint NJ, Fidelis Care and United Healthcare included their non-FIDE Dual Eligible members in the HEDIS submission, where the MCO was also the MCO for the Medicare product, which followed the NCQA HEDIS MY 2024 guidance.

- Horizon terminated the Medicare product lines on December 31, 2022; therefore, no members are reflected in Non-FIDE SNP Duals enrolled in MCO's Medicare Managed Care Product.
- Fidelis Care included their Non-FIDE SNP Duals not enrolled in MCO's Medicare Managed Care Product (Other MCO, FFS or Unknown Medicare enrollment) in the HEDIS submission.

Behavioral Health Measure Reporting

Five measures require a behavioral health benefit with the MCO. (As per NCQA General Guidelines "*If the member has partial coverage of mental health services (either by service or diagnosis), they are included as having a mental health benefit)*".

1. Follow-up After Hospitalization for Mental Illness (FUH)
2. Follow-up After Emergency Department Visit for Mental Illness (FUM)
3. Follow-up after Emergency Department Visit for Substance Use (FUA)
4. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
5. Initiation and Engagement of Substance Use Disorder Treatment (IET)

Horizon, United Healthcare and Fidelis Care choose to exclude members with partial benefit with their MCO, which is allowable under NCQA guidelines.

MLTSS Performance Measure Validation

WYE 2024 refers to the period July 1, 2023, through June 30, 2024.
WYE 2025 refers to the period July 1, 2024, through June 30, 2025.

Activities conducted during CY 2024 included validation of measures for the two WYE periods, due to the lag time for reporting some claims-based and HEDIS-based measures and updating and establishing specifications for all MLTSS PMs for WYE 2025.

All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. PM #04 is reported on a monthly basis. Four HEDIS measures and two MLTSS-specific measures (PM #47 and #54) are reported annually. All other PMs are reported on a quarterly and annual cycle. In addition to annual validation of all PMs, IPRO monitored all ongoing reporting to the state on a quarterly basis. Details of these results can be found in the **Validation of Performance Measures** section.

Final validation of WYE 2025 PMs is still ongoing. A list of all MLTSS PMs validated in WYE 2024, and WYE 2025, can be found in the **Validation of Performance Measures** section.

WYE 2024 MLTSS Performance Measure #13

The purpose of Performance Measure 13 (PM #13) was to assess if home and community-based services (HCBS) for members enrolled in MLTSS are delivered in accordance with the plan of care (POC) in type, scope, amount, frequency, and duration.

The MLTSS services assessed in PM #13 are: 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, and Private Duty Nursing. In WYE 2022, as directed by DMAHS, IPRO added the compliance score ranges for the delivery of MLTSS services.

MLTSS services that occurred between July 01, 2023, and June 30, 2024, were evaluated. POCs that only contained information regarding the members' self-directed services (e.g., Personal Preference Program) or traumatic brain injury (TBI)-specific services were excluded. If the POC indicated that a service was to begin

before the measurement period, the start date of service was set at July 01, 2023. If a service extended beyond the measurement period, the end date of service was set at June 30, 2024. Details of these results can be found in the **Validation of Performance Measures** section.

WYE 2025 MLTSS Performance Measure #13

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

The MLTSS services assessed in PM #13 are: 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 for the measurement period (July 01, 2024–June 30, 2025).

This audit is currently in progress and final results will be reflected in next year's ATR.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

The EQRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing Medicaid managed care (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. CHIP is included in the Medicaid data being presented.

In 2025, the Annual Assessment audits were conducted remotely. For the review period July 1, 2024–June 30, 2025, ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ scored above NJ's minimum threshold of 85%. Beginning in 2025, there were changes in the Access Standard Category which included Provider Network submissions and waivers that may have attributed to the increase in score for the Access category. For 2025, the average compliance score for two standards (Access and Member Disenrollment) showed increases ranging from 2 to 17 percentage points. In 2025, nine standards (Emergency and Post-Stabilization Services, QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Utilization Management, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for twelve standards (Emergency and Post-Stabilization Services, QAPI, Quality Management, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Credentialing and Recredentialing, Utilization Management, Administration and Operations, and Management Information Systems) remained the same from 2024 to 2025. One standard (Enrollee Rights and Responsibilities) showed a decrease of two percentage points from 2024 to 2025. Findings from this review can be found in the **Review of Compliance with Medicaid and CHIP Managed Care Regulations** section.

As part of the Annual Assessment of MCO operations, IPRO performed a thorough evaluation of each MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these 14 standards be evaluated. Of the 232 elements reviewed during the annual assessment, 94 crosswalk to the CMS QAPI standards. The crosswalk of the individual elements reviewed during the Annual Assessment to the CMS QAPI standards can be found in the **Review of Compliance with Medicaid and CHIP Managed Care Regulations** section.

Validation of Network Adequacy

DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how

accessibility information is presented in these look-up systems. The study methodology aligns with the CMS *External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy*. In 2025, IPRO's evaluation included the NJ FamilyCare Provider networks of ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ. Study findings can be found in the **Validation of Network Adequacy** section.

Encounter Data Validation

Encounter data validation is an ongoing process, involving the MCOs, the state Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2025, IPRO has been attending monthly EDMU calls with the MCOs and continues to monitor encounter data submissions and patterns. During 2025, IPRO also worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts and to ensure the monthly file receipt.

Quality-of-Care Surveys

Member Satisfaction – 2025 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, FC/WCHP, HNJH, UHCCP and WPNJ. Aggregate reports were produced for the adult and child surveys, and a separate report for the CAHPS Children with Chronic Conditions (CCC) survey results. The certified vendor administered three statewide surveys—Medicaid Adult, Medicaid Child, and Medicaid Child CCC. For the current reporting year, two additional surveys were stratified by MCO for the first time: the Medicaid Child CHIP Survey and the Medicaid Child CHIP CCC Survey. Details on these surveys can be found in the **Administration or Validation of Quality-of-Care Surveys** section.

Focused Studies

2025 MCO Verification of Enrollment in Care Management Focus Study

IPRO was requested to conduct a focus study on MCO verification of enrollment in CM. The purpose of this focus study was to evaluate the MCO's CM enrollment process(es) for compliance with the New Jersey FamilyCare Contract and the *NJ Care Management Workbook* requirements for the DDD and DCP&P populations. The review period for this study was July 1, 2023, through December 31, 2024, and included an offsite desk audit to review selected files, and a system review conducted with the MCOs virtually via Microsoft Teams. Details of this study can be found in the **Conducting Focus Studies of Health Care Quality** section.

Care Management Audits

2025 MCO Core Medicaid Care Management Audit and Annual Assessment

IPRO undertook Core Medicaid CM Audits of ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. The purpose of the MCO CM Audit and Annual Assessment was to evaluate the effectiveness of the contractually required CM program. DMAHS established CM requirements to ensure that the services provided to enrollees with special health care needs were consistent with professionally recognized standards of care. The populations included in this audit include general population (GP) Enrollees, Enrollees under DDD, and Enrollees under DCP&P.

Annually, DMAHS evaluates MCO performance against these requirements through its EQRO. The results of the CM Chart and CM Annual Assessment audits are used to improve MCO performance.

MCO Care Management Chart Audit

The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, up to 300 DDD, DCP&P and GP charts are reviewed for each MCO. The actual number of charts reviewed depended on the population size that met the sample criteria for the

audit. In addition to the Core Medicaid CM chart review audit, the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed *the Core Medicaid Care Management Document Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Results of this review can be found in the **Care Management Audits** section.

MCO Care Management Annual Assessment

The Annual Assessment of the Care Management and Continuity of Care standard covered the period from January 1, 2024, to December 31, 2024. There were 30 elements in this review based on contractual provisions, which are subject to review annually. Remote interviews with the MCOs were held with key MCO staff in July 2025. Overall compliance scores for the five MCOs ranged from 73% to 90% in MY2024. Results of this review can be found in the **Care Management Audits** section.

2025 MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audits

The 2025 MLTSS NF/SCNF audit was in progress during the reporting period; final audit rates will be reflected in the subsequent ATR.

2025 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. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), has established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Conclusion and MCO Recommendations

The **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section provides a summary of strengths, opportunities for improvement, and EQR recommendations for ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. These evaluations are based on the EQRO's review of MCO performance across all activities evaluated during the review period.

New Jersey Medicaid Managed Care Program

Managed Care in New Jersey

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. Per DMAHS, as of December 2025, there were approximately 1,732,376 individuals enrolled in MMC; therefore, the number increased from 1,728,928 in December 2024 (**Table 1**). Of the 1,732,376 individuals enrolled in MMC, 73,674 were receiving MLTSS services as of December 2025. More than 95% of managed-care–eligible beneficiaries receive services through the managed care program (data not shown).

In the fall of 2021, DMAHS submitted an application to CMS to renew the NJ FamilyCare Comprehensive Demonstration. This demonstration, authorized under Section 1115 of the Social Security Act, governs the operations of significant components of NJ's Medicaid program and CHIP. This demonstration is currently in its third 5-year performance period, which is scheduled to expire on June 30, 2028.

A copy of the 1115 Demonstration Renewal Draft Proposal and accompanying presentation was posted on the DMAHS website for public review and comment.

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

Five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in December 2024–December 2025. **Table 1** presents respective enrollment figures in December 2024 and December 2025.

Table 1: December 2024–December 2025 Medicaid MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2024	December 2025	December 2024[2]	December 2025
Aetna Better Health of New Jersey	ABHNJ	115,802	118,651	6,663	6,804
Fidelis Care/WellCare Health Plans of New Jersey, Inc.	FC/WCHP	87,851	85,221	13,267	14,041
Horizon NJ Health	HNJH	986,839	1,002,003	23,717	24,270
UnitedHealthcare Community Plan	UHCCP	334,936	344,929	14,139	17,109
Wellpoint New Jersey, Inc.	WPNJ	193,500	181,572	11,037	11,450
	Total	1,728,928	1,732,376	68,823	73,674

[1] Managed Long-Term Services and Supports (MLTSS) members are included in the December 2024–2025 Medicaid enrollment figures.
[2] The 2024 MLTSS-Eligible Enrollment figures have been reconciled against those reported in the prior ATR.
Source: DMAHS.

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid and MLTSS-eligible enrollment for December 2024 and December 2025 in relation to the entire NJ MMC population.

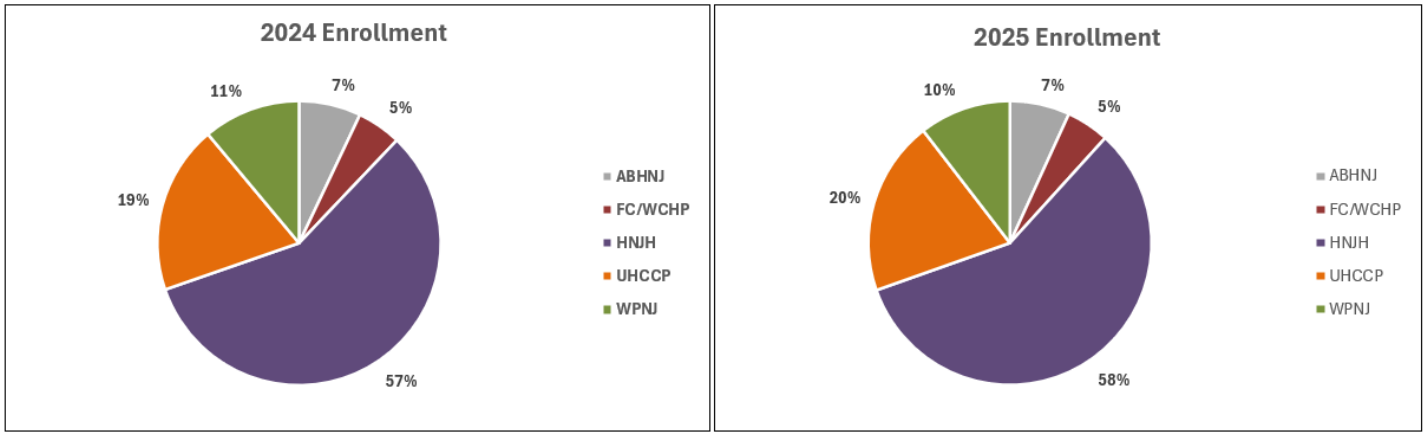

Figure 1: December 2024–December 2025 Medicaid Managed Care (MMC) Enrollment by MCO Enrollment in MMC for each MCO reported as of December 2024 (left panel) and December 2025 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (grey); FC/WCHP: Fidelis Care/WellCare Health Plans of New Jersey, Inc. (red); HNJH: Horizon NJ Health (purple); UHCCP: UnitedHealthcare Community Plan (orange). WPNJ: Wellpoint New Jersey, Inc. (green). WPNJ was formally known as Amerigroup New Jersey Inc. (AGNJ). 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: 2025 EQR Activities by MCO

EQR Activity	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Annual Assessment of MCO Operations	Yes	Yes	Yes	Yes	Yes
Performance Measures	Yes	Yes	Yes	Yes	Yes
Core Medicaid/MLTSS PIPs	Yes	Yes	Yes	Yes	Yes
Focus Quality Studies	Yes	Yes	Yes	Yes	Yes
CAHPS Surveys	Yes	Yes	Yes	Yes	Yes
Network Adequacy	Yes	Yes	Yes	Yes	Yes
Core Medicaid CM Audits	Yes	Yes	Yes	Yes	Yes
MLTSS HCBS CM AA Audits	Yes	Yes	Yes	Yes	Yes
MLTSS NF CM Audits	Yes	Yes	Yes	Yes	Yes
ISCA Assessments[1]	No	No	No	No	No

[1] A full ISCA was conducted in 2024. Healthcare Effectiveness Data and Information Set (HEDIS) information systems (IS) assessments are conducted every year, including 2024.
Yes: activity was performed; No: activity was not performed.
EQR: external quality review; MCO: Managed Care Organization; MLTSS: Managed Long-Term Services and Supports; PIP: Performance Improvement Project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: Care Management; HCBS: Home- and Community-based Services; NF: Nursing Facility; ISCA: Information Systems Capabilities Assessment.

New Jersey – 2025 State Initiatives

The information in this chapter is provided in its entirety by DMAHS and included verbatim herein. This chapter provides information on initiatives that DMAHS is undertaking to improve quality of care and information technology. DMAHS has been active in the following State Initiatives: 1115 Comprehensive Demonstration, including behavioral health services integration, housing services, and Community Health Workers (CHW) pilot; Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS); Health Information Technology (HIT) and the Medicaid Enterprise System; Maternal/Child Health, including the Quality Improvement Program – New Jersey (QIP-NJ); Managed Long-Term Services and Supports (MLTSS) HCBS Long-Term Services and Supports Quality Measure set, and Expansion of NJ WorkAbility.

1115 Comprehensive Demonstration

On March 30, 2023, the Centers for Medicare and Medicaid Services (CMS) approved the second five-year renewal of New Jersey's 1115 Comprehensive Demonstration. The renewal, authorized under Section 1115 of the Social Security Act, governs the operations of significant components of New Jersey's Medicaid program and Children's Health Insurance Program (CHIP), and is effective from April 1, 2023, through June 30, 2028. It includes integration of behavioral health services into the managed care delivery system, new housing services, continuation of programs for members in the Children's System of Care (CSOC), enhancements to the Managed Long-Term Services and Supports (MLTSS) benefits, and several other innovative projects.

A copy of New Jersey's 1115 Comprehensive Demonstration Renewal approval and Special Terms and Conditions (STC), documenting the agreement between New Jersey and CMS, can be found on the Division of Medical Assistance and Health Services (DMAHS) website for public review (https://www.nj.gov/humanservices/dmahs/home/NJFamilyCare_STCs-Technical_Corrections_11-7-2023.pdf), and periodic public comment opportunities on the progress of the Demonstration will be made available throughout the demonstration period.

The implementation of Demonstration renewal elements will be guided by the below principles:

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

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

- **Serve our communities the best way possible**:
  - Address known gaps and improve quality of care in maternal and child health.

- Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g. LGBTQ identity).

Annual Update

New Jersey continues to work with our federal partners at CMS to implement elements of the Demonstration throughout the renewal period. Implementation updates for 2025 include:

- In January 2025, New Jersey fully transitioned the services included in Phase 1 of behavioral health (BH) integration from a fee-for-service (FFS) model into managed care. This transition was supported by a defined implementation period with policy guardrails designed to protect continuity of care, minimize provider disruption, and ensure uninterrupted access to services for members. Additional phases of BH integration are planned and will continue to advance the state's broader goals of whole-person care coordination, increased access, and system alignment.
- The Housing Supports benefit went live on 7/1/2025 and the program is operating as intended. Since launch, there has been a steady increase of engagement across the program, including increasing claim submissions, growing Managed Care networks, and an increasing number of members enrolled in the program. The State continues to remain heavily engaged in its oversight role to ensure the program is functioning appropriately. Moving forward, the State will continue to refine the program and make programmatic adjustments as necessary.
- In late 2024 and throughout 2025, DMAHS and the Children's System of Care (CSOC) in the Department of Children and Families (DCF) implemented and monitored an expansion of the Children's Support Services Program for youth with I/DD. This expansion helps individuals who meet clinical and administrative eligibility criteria to enroll in Medicaid.
- New Jersey's Home Visitation Pilot, also in partnership with DCF, launched services in 2025.
- The Medically Indicated Meals pilot for pregnant women with diabetes received CMS approval to launch in 2026. The pilot will be offered to eligible managed care enrollees in two NJ FamilyCare plans: FidelisCare and UnitedHealthcare Community Plan.
- Finally, the Community Health Workers (CHW) pilot has granted preliminary approval to the proposals received from all five of NJ's managed care organizations (MCOs), and has submitted the proposals to CMS for final approval and launch in 2026.

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

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

Per CMS guidance, New Jersey has submitted and received conditional CMS approval for an initial spending plan, as well as quarterly updates to the initial plan, outlining numerous HCBS funding priorities. New Jersey's investment plan seeks to strengthen existing robust HCBS offerings, while making new investments to maintain beneficiaries' access to high-quality community-based care and addressing the ongoing effects of the COVID-19 public health emergency (PHE).

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

This spending plan lasts until March 2026, and through the quarterly update process, New Jersey continues to work with CMS to receive approval of outstanding activities, implement already approved activities, and update budget assumptions.

Health Information Technology and the Medicaid Enterprise System

The Division of Medical Assistance and Health Services (DMAHS) continues to put health information technology (HIT) at the forefront, supporting initiatives that promote interoperability to reduce healthcare costs, and improve care coordination and administrative efficiencies. The COVID-19 public health emergency (PHE), and subsequent unwinding of the PHE associated continuous Medicaid enrollment, has cast a spotlight on the importance of interoperability and health information sharing. This presented several areas of opportunity to grow the health information technology infrastructure of the State Health Information Exchange (HIE) for better care coordination and improved patient health outcomes.

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid. This includes the establishment of an overall Medicaid Enterprise System (MES) strategy that encompasses IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E), and the continuation of programs and systems developed through the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS continues to implement projects 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 CMS conditions for enhanced funding, and as applicable, achieve CMS Streamlined Modular Certification. These ensure that technology investments enable the fulfillment of programmatic goals, while creating efficiencies from utilizing modern technology.

Medicaid Management Information System (MMIS)

DMAHS continues with modernization initiatives for the MMIS (MMIS-M), which is a key component in the operation of DMAHS programs for providing comprehensive health coverage to approximately 1.8 million New Jersey residents. DMAHS continued to make strides in MMIS modernization efforts and was able to:

- Continue in advancing Provider Management Module (PMM) procurement efforts via the National Association of State Procurement Officials (NASPO) ValuePoint Cooperative Purchasing program. The

implementation of a new PMM will help realize efficiencies and benefits to business operations and improve the provider experience;

- Finalize the procurement and implementation of the Pilot Integration Platform and the scope for the legacy MMIS vendor integration requirements. The Pilot Integration Platform will support the modular upgrade and enhancement of the legacy MMIS system and validate the initial design for the end-state integration platform;
- Complete the foundational integration between the Medicaid Master Client Index (MCI) and NJ Health Information Network (NJHIN) Master Patient Index (MPI) to facilitate the exchange of protected health information (PHI) across the State agencies starting with the NJ Department of Health. This tool will continue to be utilized to support the modernization and enrichment of NJ FamilyCare/Medicaid member data across the enterprise;
- Enhance system security and operational efficiency by automating the integration between SimpliGov and SailPoint, the agency's central identity management platform. This strategic move strengthens compliance with CMS requirements, minimizes the risk of unauthorized access, and improves productivity by replacing manual workflows. This critical integration modernizes our access control system and directly supports the broader goals of the NJMMIS modernization roadmap;
- Develop the web-enabled Designated Authorized Representative (DAR) and Revocation forms in support of furthering Fee-for-Service member access control to their health information via the Patient Access Application Programming Interface (API). In addition, through a partnership with the New Jersey Innovation Institute (NJII), DMAHS will continue to support capabilities to improve patient access to health information and drive improvements in care coordination and health outcomes. In the future, planning exercises to comply with regulatory requirements to advance interoperability and improve prior authorization will be a priority;
- Develop a Tableau dashboard to provide clear visibility into essential operational metrics for both CMS and State requirements and establish a monthly operational performance review to validate these MMIS metrics. The tool empowers business subject matter experts (SMEs) during these reviews to make data-driven decisions and enhance program performance;
- Select a software product that will function as a Centralized Enterprise Test Management tool to support testing in a multi-vendor environment using a scaled agile framework (SAFe);
- Complete the comprehensive assessment and alternative analysis for the “Lift and Shift” migration of DMAHS’s Shared Data Warehouse (SDW). This project's goal is to transition the critical SDW analytics platform from an on-premises system to a modern Azure Cloud environment. DMAHS began with a comprehensive assessment and analysis of alternatives for this "lift and shift" migration. The primary outcome is to deliver a secure, cloud-based system that fully complies with all required federal and state security standards, such as HIPAA, FedRamp, and HITRUST;
- Prioritize data completeness and quality to support Transformed Medicaid Statistical Information System (T-MSIS) reporting. To this end, a concerted effort involving collaboration among cross-functional disciplines from policy, technical, and operations units has effectively addressed outstanding issues identified from the Outcomes Based Assessment (OBA). During Q1 and Q2 in FFY 2025, efforts have been instrumental in achieving and maintaining a “Blue Status” for T-MSIS, which indicates that New Jersey has met Outcomes Based Assessment (OBA) targets and passed on critical priority, high priority and expenditures. DMAHS will continue to refine its MMIS modernization roadmap to ensure alignment with program goals and priorities and utilize an outcomes-focused investment strategy.

NJ FamilyCare Integrated Eligibility System

New Jersey continued enhancements and improvements to the NJ FamilyCare Integrated Eligibility System (IES). Using a cloud-based solution, New Jersey continued enhancing the online applications for Modified Adjusted Gross Income (MAGI), Aged, Blind and Disabled (ABD), and Presumptive Eligibility (PE) programs. The online application is used by citizens, county workers, assistors and health benefits coordinators. Along with the online application, New Jersey continued enhancing the online worker portal that enables county workers to complete eligibility determinations. The worker portal automates verification, MAGI and non-MAGI eligibility determination, and NJ FamilyCare program determination.

The MAGI in the Cloud software service, designed and maintained by CMS and operated through New England States Consortium Systems Organization (NESCSO), is used to automate MAGI eligibility determination. This service allows all NJ MAGI eligibility and program determinations to be done consistently using one set of rules. NJ FamilyCare is configured to interface with the Federal Data Services Hub (FDSH) for verifications. Through FDSH, the Social Security Administration (SSA), Verify Lawful Presence (VLP), and Equifax Income verifications have all been implemented. The IES continues to maintain integration with Get Covered New Jersey, the State's official health insurance marketplace, utilizing the Account Transfer (AT) functionality. This allows for electronic transfer of beneficiary information of New Jersey residents seeking health coverage.

In 2025, New Jersey refined strategic plans to modernize the current IES, which was initially deployed to achieve the goals of the Patient Protection and Affordable Care Act (ACA). This is an ongoing process that aims to improve the functionality of the existing IES and transition the legacy mainframe Medicaid Eligibility System. Modernization project kickoff is planned for Q4 2025. In addition to working with CMS and Medicaid leadership on modernization plans, DMAHS continued with enhancements and module deployment on the current platform. They include:

- Upgrades to processing of electronic renewal applications, as part of Renewal Strategies project, which gave flexibility to counties managing application backlogs from PHE Unwind;
- Enhancements and full statewide rollout of ex-parte application processing to improve procedural renewals and minimize procedural terminations;
- Expanding automatic upload functionality to the mainframe Medicaid Eligibility System to streamline county eligibility determination; and
- Expansion of online renewals for Aged, Blind, Disabled (ABD) population.

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

Health Information Technology and the New Jersey Health Information Network

The Division of Medical Assistance and Health Services (DMAHS) continues to make significant progress in Health Information Technology (HIT) initiatives in New Jersey to enhance care coordination and improve health outcomes for New Jersey Medicaid beneficiaries. A key accomplishment for NJHIN this year is the successful migration to a modernized platform supported in-house. Previously NJHIN was maintained through the Michigan Health Information Network (MiHIN) environment and vendor services, which has now been

transitioned to in-house infrastructure supported by New Jersey Innovation Institute (NJII), enhancing platform stability, scalability and long-term sustainability.

In FY 2025, NJHIN facilitated over 84.2 million encounter notifications related to Admission, Discharge and Transfer (ADT) to the connected providers and its Trusted Data Sharing Organizations (TDSOs), representing a 4.6% increase from FY 2024 (80.5M). NJHIN enabled the exchange of more than 65.9M Clinical Continuity of Care Documents (CCDA) indicating an 87.4% increase from FY 2024 (35.2M). These metrics demonstrate sustained growth in real-time data exchange and continued provider engagement for statewide care continuum.

In an effort to streamline government processes and improve efficiency, the New Jersey Department of Health (NJDOH), in collaboration with the New Jersey Department of Human Services (NJDHS), the New Jersey Innovation Institute (NJII), and RWJ Barnabas Health, successfully launched a pilot project to leverage NJHIN to electronically transmit birth record data from hospital Electronic Health Record (EHRs) systems directly to the State's Vital Statistics Birth registry, reducing administrative workloads and increasing data accuracy. Successful launch of this initiative demonstrates how technological innovation can enhance government operations and better serve New Jersey residents.

Additionally, Aetna Better Health of NJ became the first Managed care Organization (MCO) to receive Admission Discharge and Transmission (ADT) notifications for its Medicaid members through their connectivity to NJHIN. This is a critical milestone for the managed care plan to improve care coordination and better support their members during transitions of care.

NJHIN has been instrumental in Medicaid enrollment outreach during the unwinding efforts. This effort has highlighted the importance of continuous Medicaid redetermination to maximize the continuity of coverage for approximately two million Medicaid beneficiaries. DMAHS continues to leverage NJHIN's Trusted Data Sharing Organizations (TDSOs) to optimize continuous Medicaid redetermination through provider outreach. Analysis of the monthly renewal cohorts in FY 25 indicates that the members outreached through the NJHIN connectivity resulted in lower procedural termination rates in comparison with the non-NJHIN members.

DMAHS continues to collaborate with the Division of Consumer Affairs (DCA) and remains compliant with the requirements under Section 5042 by reporting the Drug Utilization Report (DUR) leveraging the New Jersey Prescription Monitoring Program (NJPMP) database. In addition, CMS approved the DMAHS request to support the Maintenance and Operations (M&O) for FFY 2026 under the Medicaid Enterprise Systems (MES).

DMAHS continues to advance interoperability efforts among the Mental health healthcare community through the milestone-based Promoting Interoperability Programs (PIPs). The state-funded Substance Use Disorder (SUD) PIP supports SUD facilities in enhancing care coordination and improving quality of care, with over 100 facilities and 2,600 providers actively participating and benefiting from the interoperability connections established through the program milestones. The Behavioral Health (BH) PIP, launched in July 2024 under New Jersey's 1115 demonstration waiver renewal, has also received positive and enthusiastic response to participate in the program. A total of eight behavioral health facilities with 263 licensed professionals achieving a total of 19 milestones to date demonstrates continued progress toward advancing data interoperability and an integrated behavioral health care.

Maternal Health

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

New Jersey's 2025 maternal health initiatives include:

- *Piloting innovation in quality improvement*: In April 2022, NJ FamilyCare launched its perinatal episode of care pilot to test a new alternative payment for prenatal, labor, and postpartum services statewide. Its goal is to improve the quality of maternity care by incentivizing obstetrical providers to broadly engage in all aspects of their patient's care. In 2025, DMAHS concluded the episode's three-year pilot period (2022-2025) and is running a fourth episode Performance Period from 2025-2026. DMAHS announced in 2025 that NJ was among 15 states selected by CMS to participate in the Transforming Maternal Health (TMaH) Model, with federal funding support from CMS. TMaH is a CMMI Medicaid Innovation model that will involve statewide implementation of a CMS-designed maternity value-based payment for NJ FamilyCare providers. DMAHS is supporting NJ FamilyCare obstetrical providers with the transition from NJ's perinatal episode of care that is currently operating to the TMaH payment model that will launch in 2028.
- *Quality Improvement Program – New Jersey (QIP-NJ):* In conjunction with DMAHS, the Department of Health continues its administration of the QIP-NJ program, a hospital pay-for-performance initiative that launched in 2021. QIP-NJ has a dual focus of quality improvement with maternal health and behavioral health components. In 2025, fifty-eight acute care hospitals participated in the final Measurement Year 5 of the 5-year program, with forty-five participating in the maternal health component, and fifty-five participating in the behavioral health component. For more information, please see https://qip-nj.nj.gov/.

Child Health

New Jersey's 2025 child health initiatives include:

- *Integrated for Kids (InCK) Model:* DMAHS continues its support for NJ's grantees (led by Hackensack Meridian Health), who have received federal funding from CMS to implement the CMMI Medicaid Innovation model, InCK, in NJ. The NJ InCK Model has been available to pediatric NJ FamilyCare members residing in Ocean and Monmouth counties since 2022. The NJ InCK Model has two components. One is a comprehensive screening that is available to all NJ FamilyCare children. The second is voluntary, family-centered, community-based care coordination available only to the subset of children identified to have significant health complexity through screening. Both of these components are supported by a state payment model designed by the grantees and paid for by NJ FamilyCare. DMAHS and the NJ InCK grantees are working in collaboration with CMS to evaluate impact and lessons learned from operating the NJ InCK Model. The final funding year of the model is 2026. For more information, please see https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.
- *HealthySteps Reimbursement:* HealthySteps is a pediatric model of care for children ages 0-3 that is used at pediatric offices nationally. It promotes team-based care involving a trained HealthySteps Specialist, comprehensive screening, and preventive care provided through a family-centered framework. Pediatric care provided at a HealthySteps office is aligned with the American Academy of Pediatrics' Bright Futures guidelines. The enacted State budget included funding

for NJ FamilyCare to provide enhanced reimbursement for certain pediatric primary care services when provided at HealthySteps offices. This enhanced reimbursement was launched effective July 1, 2025.

MLTSS HCBS Quality Measure Set

Medicaid Long-Term Services and Supports (LTSS) are commonly delivered through managed care programs and fee-for-service (FFS) programs. In May 2019, the Centers for Medicare & Medicaid Services (CMS) selected and published an initial set of eight quality measures, evaluating the delivery of the Managed Long-Term Services and Supports (MLTSS) program for voluntary use by states. In 2022, CMS released updates to the MLTSS measures, including changes to the measure names, clarifications to support measure compliance, and links to updated value sets. In this update to the measures, CMS has included the introduction of a set of corresponding measures for Medicaid FFS LTSS programs and made further clarifications to the Medicaid MLTSS measures.

MLTSS has initiated ten Long-Term Services and Supports, Home and Community Based Services (HCBS) Quality Measures to align with the 1115 HCBS Quality Strategy framework designed by CMS for MLTSS. These performance measures are designed to assess the quality of the Medicaid LTSS program for the HCBS population. CMS has outlined specific guidance on implementation of the Quality Measures. DMAHS will be implementing these new measures for the MLTSS population, as well as a data stratification of Money Follow Person (MFP) for two specific Quality Measures. DMAHS has worked in collaboration with the EQRO to create specifications from Healthcare Effectiveness Data and Information Set (HEDIS)/National Committee for Quality Assurance (NCQA) and CMS, to implement, validate and monitor these performance measures.

Expansion of NJ WorkAbility

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

Of note, CMS has not approved eligible applicants to remain enrolled for up to a year after a job loss if not the fault of the member in the state plan amendment (SPA). CMS provided guidance that this request may be submitted through New Jersey's 1115 Comprehensive Demonstration.
Since February 1, 2024, NJ WorkAbility completed phase 2 system changes and received CMS approval of NJ's SPA (NJ-24-0006), expanding program eligibility to applicants with countable income over 250% of the Federal Poverty Level (FPL) who agree to pay a premium. Phase 2 enrollment remains slow and steady, as outreach expands to working individuals with disabilities whose incomes are above 250% FPL and are now eligible for Medicaid services that were not previously accessible.

New Jersey DMAHS Quality Strategy

New Jersey maintains rigorous standards to ensure that approved health plans have networks and quality management programs necessary to serve all enrolled populations. New Jersey's quality strategy serves as a roadmap for ongoing improvements in care delivery and outcomes. Whether it be through new benefits and services, innovations, technology, or managed care accountability, NJ DMAHS is committed to serving Medicaid beneficiaries the best way possible. The revised New Jersey DMAHS Quality Strategy is expected to be released later in 2026.

CMS Aim 1: Better Care

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

CMS Aim 2: Smarter Spending

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

CMS Aim 3: Healthier People, Healthier Communities

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

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

Table 3: NJ DMAHS 2022 Quality Strategy Goals

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

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

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

MMIS: Medicaid Management Information System; T-MSIS: Transformed Medicaid Statistical Information System.

IPRO's Assessment of the New Jersey DMAHS Quality Strategy

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

Recommendations to New Jersey DMAHS

Per *Title 42 CFR § 438.364 External quality review results (a)(4)*, this ATR report is required to include recommendations on how NJ DMAHS can target the goals and the objectives outlined in NJ's Quality Strategy

to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to NJ MMC enrollees. As such, IPRO recommended the following to NJ DMAHS:

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

NJ EQR Activities' Timeline

Table 4 presents the timeline for the Core Medicaid/MLTSS activities described in this report.

Table 4: Core Medicaid/MLTSS Activities' Timeline

EQR Activity	Description	Data Period	Timing of Activity
***CMS Mandatory Protocol 1*:** Validation of Performance Improvement Projects (PIPs)	This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services. 1, 2, 3 - Annual PIP submissions from MCOs.	January 1, 2024 – July 1, 2025	1. PIP Status – April 2025 2. PIP Report – August 2025 3. PIP Proposal – September 2025
CMS Mandatory Protocol 2: Validation of Performance Measures	This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.	January 1, 2024 – December 31, 2024	June 2025
CMS Mandatory Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations	This activity determines MCO compliance with its contract and with state and federal regulations.	July 1, 2024 – June 30, 2025	September 2025
CMS Mandatory Protocol 4: Validation of Network Adequacy	This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population.	August 1, 2025 – September 30, 2025	January 2026
CMS Optional Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan	This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.	January 1, 2025 – August 31, 2025	Monthly – January 1, 2025 – December 31, 2025
CMS Optional Protocol 6: Administration or Validation of Quality-of-Care Surveys	Satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.	March 1, 2025 – December 31, 2025	February 2025
CMS Optional Protocol 7: Calculation of Additional Performance Measures	One purpose of quality measurement is to evaluate the degree to which evidence-based treatment guidelines are followed, where indicated, and to assess the results of care.		

EQR Activity	Description	Data Period	Timing of Activity
CMS Optional Protocol 8: Implementation of Additional Performance Improvement Projects	In addition, Federal regulations at 42 CFR 438.358(c)(4) and 457.1250(a) specify that the external quality review organization (EQRO) may conduct PIPs in addition to those performed by the MCOs as a part of their QAPI programs.		
CMS Optional Protocol 9: Conducting Focus Studies of Health Care	This activity conducts clinical and nonclinical focus studies to assess quality of care at a point in time.	January 1, 2025 – December 31, 2025	Ongoing
Core Medicaid Care Management Review	To evaluate the effectiveness of the contractually required Care Management (CM) program.	January 1, 2024 – December 31, 2024	March 2025
MLTSS – Home and Community Based Services (HCBS) Care Management Review	This activity assesses the effectiveness of the MLTSS Care Management program as required by contract, ensuring that services are appropriately delivered to special needs members who qualify for MLTSS under Home and Community-Based Services (HCBS) eligibility criteria.	July 1, 2024 – June 30, 2025	January 2026
MLTSS – Nursing Facility Care Management Review	This activity assesses the effectiveness of the contractually mandated MLTSS Care Management program and verifies that services are delivered to special needs members who meet MLTSS eligibility requirements and qualify for institutionalization in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF) for long-term care.	July 1, 2024 – June 30, 2025	February 2026
EQR Annual Technical Report (ATR)	Results of all EQR-related activities. CMS requires that all states have final EQR technical reports available to CMS and the public by April 30 of each year.	January 1, 2025 – December 31, 2025	April 2026

Protocol 1: Validation of Performance Improvement Projects

Objectives

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

In accordance with Article 4.6.2.Q – PIPs of the NJ FamilyCare Managed Care Contract, MCOs are required to design, implement, and report results for each study topic area defined by DMAHS. IPRO conducted a comprehensive evaluation of each MCO's PIPs to determine compliance with the CMS protocol, *Validation of 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.

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, i.e., 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–December 2025, this ATR includes IPRO's evaluation of the April 2025 PIP update and August 2025 PIP report submissions as well as one PIP proposal submission. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure the PIP met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQR protocols. The MCOs will continue to submit project updates in April and August progress reports each year.

In June 2025, IPRO conducted the annual PIP training for the MCOs. The training focused on PIP development, implementation, and current PIP issues, as well as review of new PIP proposals.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the DMAHS contracted with IPRO to validate the PIPs that were underway in 2025 (**Table 5**). Unless indicated as nonclinical, PIPs were clinical. PIPs that were at the final report stage or proposal are noted.

Table 5: Core Medicaid and MLTSS PIP Topics

MCO	MCO PIP Title(s)[1]	State Topic
Aetna Better Health New Jersey (ABHNJ)	**PIP 1[2]:** Improving Access and Availability to Primary Care for the Medicaid Population (Core Medicaid)	Access and Availability (Nonclinical)
	PIP 2[2]: Increasing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits and Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP 3: Decreasing Member Grievances Related to Balance Billing (Core Medicaid)	Member Grievances (Nonclinical)
	PIP 4: Increasing IMA Combination 2 Vaccinations and Well Child Visits (Core Medicaid)	Immunizations for Adolescents

MCO	MCO PIP Title(s)[1]	State Topic
	PIP 5[2]: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
	PIP 6: Increasing the number of 10-day post-discharge visits with assessment for the MLTSS population (MLTSS)	Increasing 10-day Post-Discharge Visit with Assessment
Fidelis Care/ WellCare Health Plans of New Jersey, Inc. (FC/WCHP)	**PIP 1[2]:** Improving Early and Periodic Screening, Diagnostic, and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP 2: Addressing Medicaid Members' Complaints and Grievances (Core Medicaid)	Member Grievances (Nonclinical)
	PIP Proposal: Improving Compliance with Adolescent Immunizations specifically targeting the completion of meningococcal vaccine, Tdap vaccine, and full HPV vaccine series (Core Medicaid)[3]	Immunizations for Adolescents
	PIP 3[2]: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
	PIP 4: Improving Timely 10-Day Post-Discharge Visits from The Acute Care Setting with Assessment by The Care Manager in The MLTSS HCBS/Core Medicaid and DSNP population. (MLTSS)	Increasing 10-day Post-Discharge Visit with Assessment
Horizon NJ Health (HNJH)	**PIP 1[2]:** Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population. (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP 2: Complaints and Grievances (Core Medicaid)	Member Grievances (Nonclinical)
	PIP 3: IMA Combo-2 PIP (Core Medicaid)	Immunizations for Adolescents
	PIP 4[2]: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
	PIP 5: MLTSS 10-day Post-Discharge Visits with Assessment	Increasing 10-day Post-Discharge Visit with Assessment
UnitedHealthcare Community Plan (UHCCP)	**PIP 1[2]:** Improving Frequency of Well Visits in the First 30 months of Life and Compliance with Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP 2: Reducing Member Grievances for Medicaid Members (Core Medicaid)	Member Grievances (Nonclinical)
	PIP 3: Immunizations for Adolescents (IMA) (Core Medicaid)	Immunizations for Adolescents

MCO	MCO PIP Title(s)[1]	State Topic
	PIP 4[2]: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
	PIP 5: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members (MLTSS)	Increasing 10-day Post-Discharge Visit with Assessment
Wellpoint New Jersey, Inc. (WPNJ)	**PIP 1[2]:** Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP 2: Decreasing Member Grievances Related to Balance Billing Issues (Core Medicaid)	Member Grievances (Nonclinical)
	PIP 3: Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance (Core Medicaid)	Immunizations for Adolescents
	PIP 4[2]: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS Home and Community Based Population (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
	PIP 5: Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members (MLTSS)	Increasing 10-day Post-Discharge Visit with Assessment

[1] Includes Performance Improvement Projects (PIPs) that started, are ongoing, and/or were completed in the review year.

[2] Indicates final report.

[3] FC/WCHP is operating one cycle behind the other four MCOs in the IMA PIP.

Technical Methods of Data Collection and Analysis

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

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

Review Element 1:	Topic and Rationale
Review Element 2:	Aim
Review Element 3:	Methodology: • Study Population • Study Indicator • Sampling
Review Element 4:	Barrier Analysis
Review Element 5:	Robust Interventions: • Improvement Strategies
Review Element 6:	Results Table: • Data Collection
Review Element 7:	Discussion and Validity of Reported Improvement: • Likelihood of real improvement
Review Element 8:	Sustainability
Review Element 9:	Healthcare Disparities (not included in scoring)

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

Table 6: PIP Validation Scoring and Compliance Levels

IPRO Validation Level	CMS Rating	Scoring Range	Compliance Score Range Criteria
Met	High	≥ 85% for Core Medicaid ≥ 86% for MLTSS	The MCO has demonstrated that it addressed the requirement.
Partial met	Moderate	60%-84% for Core Medicaid 60%-85% for MLTSS	The MCO has demonstrated that it addressed the requirement, however not in its entirety.
Not met (non-compliant)	Low	Below 60%	The MCO has not addressed the requirement.
N/A	N/A	N/A	Unable to evaluate performance at this time.

PIP: Performance Improvement Project; CMS: Centers of Medicare and Medicaid Services; MLTSS: Managed Long-Term Services and Supports; MCO: Managed Care Organization; N/A: Not Applicable.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO reviewed the August 2025 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies (**Tables 7–12**). Note: Amerigroup New Jersey, Inc. (AGNJ) began doing business as Wellpoint NJ (WPNJ) on 1/1/2024. Current MCO-specific PIP scoring reports along with IPRO findings can be found in **Appendix A: January 2025–December 2025 NJ MCO-Specific Review Findings**.

Table 7: PIP State Topic #1: Core Medicaid Primary Care Providers Access and Availability

New Jersey MCO PIP Scoring Report PCP Access and Availability (Nonclinical)	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final[1]	FC/WCHP	HNJH	UHCCP	WPNJ
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	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	M	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	M	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**5.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	PM	N/A	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	M	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	**PM**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**50**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**2.5**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	N/A	N/A	N/A	N/A
3b. Performance Indicators are measured consistently over time	M	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes 3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M M	N/A N/A	N/A N/A	N/A N/A	N/A N/A

New Jersey MCO PIP Scoring Report PCP Access and Availability (Nonclinical)	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final[1]	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	M	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	N/A	N/A	N/A	N/A
3h. Study design specifies data analysis procedures with a corresponding timeline	M	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**15.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	M	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	M	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	N/A	N/A	N/A	N/A
4f. Literature review	M	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**15.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	M	N/A	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	M	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**15.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**5.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7. Discussion and Validity of Reported Improvement (20% weight)					

New Jersey MCO PIP Scoring Report PCP Access and Availability (Nonclinical)	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final[1]	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
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	N/A	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	M	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**M**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**100**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**20.0**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	PM	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**PM**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**50**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**10.0**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N/A**	**N/A**	**N/A**	**N/A**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	N/A	N/A	N/A	N/A
Actual Weighted Total Score	**87.5**	N/A	N/A	N/A	N/A
Validation Rating Percent	**87.5%**	N/A	N/A	N/A	N/A
Validation Status	**Yes**	**N/A**	**N/A**	**N/A**	**N/A**
Validation Rating	**High**	**N/A**	**N/A**	**N/A**	**N/A**

≥ 85% met, "High"; 60-84% partial met (corrective action plan), "Moderate"; < 60% not met (corrective action plan), "Low".

[1] ABHNJ is one cycle behind for this PIP.

Table 8: PIP State Topic #2: Core Medicaid EPSDT Well Child Visits, Childhood Immunizations

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	M	M	M	M	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	PM
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	PM	M	PM	M
5b. Actions that target member, provider and MCO	M	PM	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**M**	**PM**	**M**	**PM**	**M**
Element 5 Overall Score	**100**	**50**	**100**	**50**	**100**
Element 5 Weighted Score	**15.0**	**7.5**	**15.0**	**7.5**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	PM	PM	PM	PM	M
Element 8 Overall Review Determination	**PM**	**PM**	**PM**	**PM**	**M**
Element 8 Overall Score	**50**	**50**	**50**	**50**	**100**
Element 8 Weighted Score	**10.0**	**10.0**	**10.0**	**10.0**	**20.0**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ Final	FC/WCHP Final	HNJH Final	UHCCP Final	WPNJ Final
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**90.0**	**82.5**	**90.0**	**82.5**	**92.5**
Validation Rating Percent	**90.0%**	**82.5%**	**90.0%**	**82.5%**	**92.5%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**Moderate**	**High**	**Moderate**	**High**

≥ 85% met, "High"; 60-84% partial met (corrective action plan), "Moderate"; < 60% not met (corrective action plan), "Low".

Table 9: PIP State Topic #3: Core Medicaid Member Grievances

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 2	FC/WCHP MY 2	HNJH MY 2	UHCCP MY 2	WPNJ MY 2
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	PM	PM	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	PM	M	M	M	M
Element 2 Overall Review Determination	**PM**	**PM**	**PM**	**M**	**M**
Element 2 Overall Score	**50**	**50**	**50**	**100**	**100**
Element 2 Weighted Score	**2.5**	**2.5**	**2.5**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**FC/WCHP MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**WPNJ MY 2**
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	PM	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	N/A	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**7.5**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data (“5 Why’s”, fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	N/A	M
4f. Literature review	M	M	M	N/A	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	PM	M	PM
5c. New or enhanced, starting after baseline year	M	N/A	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	PM	M	M
Element 5 Overall Review Determination	**PM**	**M**	**PM**	**M**	**PM**
Element 5 Overall Score	**50**	**100**	**50**	**100**	**50**
Element 5 Weighted Score	**7.5**	**15.0**	**7.5**	**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**FC/WCHP MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**WPNJ MY 2**
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	N	N	N	N	N
	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**70.0**	**70.0**	**70.0**	**80.0**	**72.5**
Validation Rating Percent	**87.5%**	**87.5%**	**87.5%**	**100.0%**	**90.6%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**High**	**High**	**High**	**High**

≥ 85% met, “High”; 60-84% partial met (corrective action plan), “Moderate”; < 60% not met (corrective action plan), “Low”.

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

Table 10: PIP State Topic #4: Core Medicaid Member IMA

New Jersey MCO PIP Scoring Report IMA MY=Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**FC/WCHP[1]**	**HNJH MY 1**	**UHCCP MY 1**	**WPNJ MY 1**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	N/A	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	N/A	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	N/A	M	M	M
1d. Reflects high-volume or high risk-conditions	M	N/A	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	N/A	M	M	M
Element 1 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**N/A**	**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	N/A	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	N/A	M	M	M
2c. Objectives align aim and goals with interventions	M	N/A	M	M	M
Element 2 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**N/A**	**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	N/A	M	M	M
3b. Performance Indicators are measured consistently over time	M	N/A	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	N/A	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	N/A	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	N/A	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	M	N/A	M	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	N/A	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	N/A	M	M	M
Element 3 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**N/A**	**15.0**	**15.0**	**15.0**

New Jersey MCO PIP Scoring Report IMA MY=Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	FC/WCHP[1]	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
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	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	N/A	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	N/A	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	N/A	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	N/A	M	M	M
4f. Literature review	M	N/A	M	M	M
Element 4 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**N/A**	**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	N/A	M	M	M
5b. Actions that target member, provider and MCO	M	N/A	M	M	M
5c. New or enhanced, starting after baseline year	M	N/A	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	N/A	M	M	M
Element 5 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 5 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 5 Weighted Score	**15.0**	**N/A**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	N/A	M	PM	M
Element 6 Overall Review Determination	**M**	**N/A**	**M**	**PM**	**M**
Element 6 Overall Score	**100**	**N/A**	**100**	**50**	**100**
Element 6 Weighted Score	**5.0**	**N/A**	**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)	M	N/A	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	N/A	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	N/A	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	N/A	M	M	M
Element 7 Overall Review Determination	**M**	**N/A**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**N/A**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**N/A**	**20.0**	**20.0**	**20.0**

New Jersey MCO PIP Scoring Report IMA MY=Measurement Year	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 1	FC/WCHP[1]	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
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 were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	**Y**	**N/A**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**N/A**	**80**	**80**	**80**
Actual Weighted Total Score	**80.0**	**N/A**	**80.0**	**77.5**	**80.0**
Validation Rating Percent	**100.0%**	**N/A**	**100.0 %**	**96.9%**	**100.0%**
Validation Status	**Yes**	**N/A**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**N/A**	**High**	**High**	**High**

[1]MCO is at the proposal stage for this PIP and will be scored in MY 1.
Element 8 is not scored during measurement years 1 and 2.

Table 11: PIP State Topic #5: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical)	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ Final	FC/WCHP Final	HNJH Final	UHCCP Final	WPNJ Final
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical)	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	M	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical)	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ Final	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 5 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 5 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	M	PM	M	PM	M
Element 8 Overall Review Determination	**M**	**PM**	**M**	**PM**	**M**
Element 8 Overall Score	**100**	**50**	**100**	**50**	**100**
Element 8 Weighted Score	**20.0**	**10.0**	**20.0**	**10.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**
	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**100.0**	**90.0**	**100.0**	**90.0**	**100.0**
Validation Rating Percent	**100.0%**	**90.0%**	**100.0%**	**90.0%**	**100.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) Validation Rating	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ Final	FC/WCHP Final	HNJH Final	UHCCP Final	WPNJ Final
	High	High	High	High	High

≥ 86% met, "High"; 60-85% partial met (corrective action plan), "Moderate"; < 60% not met (corrective action plan), "Low".

Table 12: PIP State Topic #6: MLTSS Increasing 10-Day Post Discharge Visits with Assessments

New Jersey MCO PIP Scoring Report MLTSS 10-Day Post Discharge MY=Measurement Year	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 1	FC/WCHP MY 1	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	PM	M	M
Element 1 Overall Review Determination	**M**	**M**	**PM**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**50**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**2.5**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval	M	M	N/A	M	M

New Jersey MCO PIP Scoring Report MLTSS 10-Day Post Discharge MY=Measurement Year	IPRO 2025 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 1	FC/WCHP MY 1	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 5 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 5 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M

New Jersey MCO PIP Scoring Report MLTSS 10-Day Post Discharge MY=Measurement Year	IPRO 2025 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**FC/WCHP MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WPNJ MY 1**
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	**N**	**N**	**Y**	**N**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**80.0**	**80.0**	**77.5**	**80.0**	**80.0**
Validation Rating Percent	**100.0 %**	**100.0%**	**97.0%**	**100.0%**	**100.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**High**	**High**	**High**	**High**

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

Table 13 presents comparative performance for all MCOs across all PIP topics reviewed August 2025.

Table 13: 2025 PIP Validation Results

MCO	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
PIP 1: Access and Availability **(Non-Clinical)**[1,4]	87.5%	N/A	N/A	N/A	N/A
PIP 2: EPSDT – Well-Child Visits & Childhood Immunizations **(Clinical)**[1]	90.0%	82.5%	90.0%	82.5%	92.5%
PIP 3: Member Grievances **(Non-Clinical)**[1]	87.5%	87.5%	87.5%	100.0%	90.6%
PIP 4: Immunizations for Adolescents (IMA) **(Clinical)**[1,2]	100.0%	N/A[2]	100.0%	96.9%	100.0%
PIP 5: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population **(Clinical)**[3]	100.0%	90.0%	100.0%	90.0%	100.0%
PIP 6: MLTSS 10-Day Post Discharge Visit with Assessment **(Clinical)**[3]	100.0%	100.0%	97.0%	100.0%	100.0%

[1] Performance improvement projects (PIPs) 1, 2, 3 and 4 are Core Medicaid PIPs.
[2] Managed Care Organizations (MCOs) are at the proposal stage for this PIP and will be scored in measurement year (MY) 1.
[3] PIPs 5 and 6 are Managed Long-Term Services and Supports (MLTSS) PIPs.
[4] ABHNJ is currently one cycle behind on this PIP.
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; HCBS: Home and Community Based Services.

Strengths

ABHNJ – Of the 6 PIPs scored, 4 performed above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.

FC/WCHP– Of the 4 PIPs scored, 1 performed above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.

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

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

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

Opportunities for Improvement

ABHNJ – Overall, ABHNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions and ensure that all data presented is calculated accurately.

FC/WCHP– Overall, FC/WCHP was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring barrier analyses are comprehensive and drive appropriate interventions and sufficiently address factors that impact external validity of performance indicator results. The MCO should ensure that all data presented is calculated accurately.

HNJH – Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions.

UHCCP – Overall, UHCCP was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions.

WPNJ – Overall, WPNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions and ensure that all data presented is calculated accurately.

One MCO engaged in a Core Medicaid PIP relating to Access and Availability. **Table 14** lists the interventions that MCO implemented for this project and were provided verbatim by the MCO.

Table 14: PIP Interventions Summary 2024–2025 for Access and Availability

PIP	Interventions
ABHNJ - Improving Access and Availability to Primary Care for the Medicaid Population	• **New Member Roster to Targeted PCPs** -Plan to give monthly roster to targeted providers identifying members on panel with new members flagged for outreach for a baseline appointment. Appointments to be monitored through quarterly claims data for an initial appointment and will be reported within the quarter that the claim is received. • **ER Notification to Targeted PCPs** – Plan to give monthly list of members who were seen in the ER for a LANE diagnosis, date of ER visit, diagnosis, and date of last PCP visit for provider follow-up. It will be the expectation of the PCP to follow-up with members who visited the ER and had no PCP visits within the past 12 months to contact the member and schedule an annual visit to establish a relationship with the member and educate the member regarding appropriate use of the ER. Monitor claims for PCP visit after ER notification given to provider. • **Practice Transformation Appointment Scheduling** – Plan to survey and work with targeted PCP offices to review and modify member triage and appointment scheduling procedures during business hours, as appropriate. Discussion to occur on a quarterly basis with provider/practice manager. • **Practice Transformation After-Hours Access** -Plan to survey and work with targeted practices to review and modify after-hours triage, as appropriate. Discussion to occur on quarterly basis with provider/practice manager. • **Member Outreach (Not Seeing Assigned PCP)** – Plan to identify members assigned to PCP practice without PCP claims in system on a quarterly basis (12-month look-back) and conduct outreach to educated on the importance of a PCP and regular visits for preventive care. Members may request a new PCP assignment and will be referred to Member Services to complete the reassignment. • **Member Education** – Plan will develop flyer for member distribution to educate on the importance of PCP, appropriate use of ER, and availability of a 24-hour nurse line (Informed Health Line). Monitor distribution and subsequent ER visits > 14 days post mailing. • **Annual mailings** (1st quarter of each MY) will be conducted to all existing members assigned to targeted PCPs followed by mailings to new members assigned to targeted providers during the remaining quarters of the MY. • **24-Hour Nurse Line (Informed Health Line)** - Educate members regarding availability of "24-Hour Nurse Line" and monitor utilization of this vendor on a quarterly basis.

PIP	Interventions
	• **Survey members assigned to targeted practices via IVR** questionnaire to answer questions regarding Getting Needed Care. This information will be shared with PCP practice for opportunities of improvement and monitored for performance through quarterly surveys. • **Annual surveys** (1st quarter of each MY) will be conducted to all existing members assigned to targeted PCPs followed by surveys to new members assigned to targeted providers the remaining quarters of the MY. This information will be shared with PCP practice for opportunities of improvement and monitored for performance through quarterly surveys.

PIP: Performance Improvement Project; PCP: Primary Care Provider; ER: Emergency Room; LANE: Low-acuity, Non-emergent; MY: Measurement Year; IVR: Interactive Voice Response.

All five MCOs engaged in a Core Medicaid PIP relating to EPSDT. **Table 15** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 15: PIP Interventions Summary 2024–2025 for EPSDT: Increasing Early and Periodic Screening, Diagnostic, and Treatment Visits and Childhood Immunizations

PIP	Interventions
ABHNJ - Increasing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits and Childhood Immunizations	• **Educate non-adherent members** with well child visits and/or immunizations about importance of visits and safety of vaccines via IVR through mPulse (formerly known as HealthCrowd). The Plan will be specifically tracking the African American children for non-adherence due to vaccine hesitancy and lack of trust in the medical community. • **Identify members** without PCP claims in the system on a quarterly basis (12-month look-back) and conduct member outreach for engagement and/or PCP reassignment. • **Provide roster to select providers** in targeted counties identifying new members on the panel with no well-child visits and/or no CIS combo 10 (formerly combo 9) vaccinations. Appointments to be monitored through quarterly claims data. • **Send letter to members** with a brochure who do not have claims for well-child visits and/or CIS combo 10 (formerly combo 9) vaccinations on behalf of PCP for select provider offices that ABHNJ manages and mailings which include incentive information. The member letter will include the provider and Plan logo with the provider signature.
FC/WCHP-Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations	• **Member Outreach** by Care Coordinator to educate screen and engage in care management. • **Provide the following educational website** for parent/guardian education: Share and discuss the *NEW Bright Futures Family Tip Sheet* consistent with *Bright Futures Guidelines*, *The Well-Child Visit: Why Go and What to Expect*. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_Family_Tipsheet.pdf • **Provide the following educational materials** via mailings for parent/guardian education: Childhood Vaccine Schedule Krames; Well Child Check-up Krames; Preventative Guidelines Ages 2-18 Krames. • **Educate parent/guardian** on the MyHealthPays Rewards Program. • **Implementation of monthly** parent/guardian outreach to educate new mothers on the importance of well-child visits and immunizations. • **Quarterly Engagement** of 2 pilot providers to include: - Provider Education of the PIP - Delivery of Provider Score Card to include WCV/Immunization Care Gaps

PIP	Interventions
	- Familiarize provider with the Bright Futures Performing Preventive Services Handbook, which provides guidance on the most effective way to deliver the preventive services recommended in the *Bright Futures Guidelines,* 4th Edition. https://brightfutures.aap.org/clinical-practice/Pages/default.aspx> • **Provide prenatal education** regarding Bright Futures Vaccine Schedule and Well Child Visits. • **Mail expectant mothers** the 2021 Bright Futures Vaccine Schedule and Well Child Visits. • **To outreach parents/guardians** with members having open W30 and CIS care gaps that may be due to a potential language barrier in a particular county. • **To identify parents/guardians** with members having open W30 and CIS care gaps who confirmed language barriers in a particular county and transition them to a provider who spoke their chosen language.
HNJH - Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population.	• **Parent/guardians** of new HNJH members less than 30 months of age will be sent targeted mailer highlighting recommended immunization schedule and the ability to obtain combination doses. Phone number for scheduling assistance will also be included. • **Quarterly member gap lists** to primary care providers caring for children less than 30 months of age with list of members due for upcoming WCV and CIS to better assist in appointment scheduling prior to recommended WCVs and CIS. • **Parent/guardians** of HNJH members sent a reminder postcard that the member is behind schedule to complete six (6) well-child visits with their PCP by 15 months of age. Children 12 months of age or older with no well-child visits on record will be targeted for the reminder. • **Parent/guardians of HNJH** members sent a reminder postcard that the member is behind schedule to complete two (2) well-child visits with their PCP by 30 months of age. Children 22 months of age or older with no well-child visits on record will be targeted for the reminder. • **Semi-annually deliver flier** to PCPs explaining ModivCare availability and how members may utilize their services to access the PCP. Information can be disseminated when attempting to schedule members with transportation challenges.
UHCCP - Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations.	• **Outreach to the parents/caregivers** of members assigned to Practice 1, 2 and 3 to remind them to schedule/keep their scheduled well baby appointments, educate on importance of preventive care. • **Provide case management** referral to parents/caregivers of members assigned to Practice 1, 2 and 3 who express that social determinants of health (relating to food, housing, or transportation) present a barrier to bringing their child for the well-baby visits. • **Monthly practice outreach/education** by UHCCP Clinical Practice Consultants (CPCs) to the staff at Practice 1, 2 and 3 regarding scheduling the well-baby appointment before the parent/caregiver leaves the office after a well-baby visit and reinforcing the importance of providing education to the member parent/caregiver regarding adherence to the recommended immunization and well-baby visit schedule.
WPNJ - Improving Well-Child	• **Parent/guardian education** on the importance of well visits and immunizations. • **Telephonic outreach** to parents/guardians of children ages 0-30 months identified as missing well visits.

PIP	Interventions
Visits and Immunization Rates for Members Ages 0-30 Months	• **Parents/guardians** with children ages 0-30 months identified as missing well visits that required transportation assistance during telephonic outreach. • **Web-based member education** regarding vaccine safety. • **Outreach to providers** identified as having 10% or more of eligible members with gaps in care for well visits and immunizations. • **Targeted education for pediatricians** and family practice physicians on correct coding of well visits via fax blast. • **Implementation and promotion** of provider incentive for vaccine administration. • **Outreach to Passaic County provider groups** with gaps in care for well visits and immunizations to provide best practices and education (15 or more gaps in care for identified membership with disparity in Passaic County). • **Targeted education via text or telephonic outreach** to identified parents/guardians of children ages 0-30 months identified as missing well visits and immunizations (Passaic County membership with disparity - Hispanic).

PIP: Performance Improvement Project; PCP: Primary Care Provider; IVR: Interactive Voice Response; CIS: Childhood Immunization Status; WCV: Well-child Visit.

All five MCOs engaged in a Core Medicaid PIP relating to Member Grievances. **Table 16** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 16: PIP Interventions Summary 2024–2025 for Member Grievances

PIP	Interventions
ABHNJ – Decreasing Member Grievances Related to Balance Billing	• **Educate new members** about Plan requirements (par and non-par, covered services, what requires pre-cert) and what to do if balance-billed through the updated Hello to Health magazine and Member Handbook. • **Outreach existing members** who submitted two or more grievances categorized as balance billing for par providers within the quarter to educate members on Plan requirements and balance billing regulations. • **Send a revised cease and desist letter** to all providers who balance billed a member within the quarter. • **Par providers with 4 or more member grievances** categorized as balance-billing will be outreached by the Plan with the list of members who submitted a grievance and will be given 30 days to respond. If no response is received from the provider, a face to face visit will be arranged. • **Outreach non-par providers where a single case agreement** was put in place for at least one case and for whom the Plan received a grievance categorized as balance-billing and monitor which of these providers was subsequently added to the network. • **Develop and implement a new form** for verbal member grievances received by the Member Call Center staff to ensure complete and accurate documentation of all data necessary for grievance resolution.
FC/WCHP-Addressing Medicaid Members' Complaints and Grievances	• **We will use our quarterly newsletter** to remind our members about their rights under Medicaid and provide clarity regarding balance billing practices. • **We will conduct quarterly outreach** to our Medicaid members who have opened a balance billing grievance to provide clarity regarding balance billing practices and their rights. • **During our in-person and virtual visits**, we will educate our providers with a one-page flyer that outlines facts regarding balance billing Medicaid members.

PIP	Interventions
	• **We have added a slide to the existing onboarding material** for new providers to the plan regarding balance billing. • **Quarterly education regarding balance billing** added to calendar of provider trainings. • **Enhancement of Fidelis Care's Explanation of Payment (EOP)** to include language regarding not balance billing Medicaid members. • **Executive Leadership outreaching providers** who continue to balance bill members (identified by new balance billing grievances being opened) to ensure they cease billing members.
HNJH - Complaints and Grievances – Core Medicaid Membership	• **Quarterly educational materials and training** provided to Medicaid providers regarding positive member interaction topics including, but not limited to de-escalation, thoughtful responding, and supporting people experiencing crisis. • **Quarterly educational materials** regarding top trending complaints provided to Medicaid practitioners, hospital facilities, and stand-alone diagnostic centers.
UHCCP – Reducing Member Grievances for Medicaid Members	• **Educate all in-network provider practices and facilities** on proper Medicaid billing, as outlined in the Provider Manual. • **Post an annual provider bulletin** on the NJUHCCP provider website to review Medicaid rules related to member billing as outlined in the Provider Manual. • **Implement ongoing quarterly training** via required assigned learning modules for all member service representatives to improve quality of member interactions. • **Monitor post-call member surveys** for indicators of dissatisfaction and provide individual call center representative coaching to improve performance and call handling. • **Monitor percent of post-call member surveys** that indicated member dissatisfaction with the call experience. • **Implement ongoing group training** for call center representatives identified as needing additional training to improve the quality of member interactions. • **Inform members about their rights and responsibilities** regarding balance-billing through an annual article in the member newsletter. • **Focus on the post-call detractor** surveys in which members indicated that their issue was not resolved during the call (rating of 0-6 on the 0-10 scale for Question 3 of the post-call survey). Report percentage of these surveys for which the call center management successfully connected with the members and assisted them with issue resolution.
WPNJ - Decreasing Member Grievances Related to Balance Billing	• **Follow-up education via fax related to balance billing** of Medicaid members directed to providers/groups who had a member grievance reported under the balance billing category in the prior month. • **Follow-up education on balance billing** of Medicaid members conducted by the Provider Relations team to the unique out-of-network providers/groups who had a member balance billing grievance in the prior month. • **Follow-up education on balance billing** of Medicaid members conducted by the Provider Relations team to the unique in-network providers/groups who had a member balance billing grievance in the prior month. • **Include educational information** about balance billing rights for Medicaid members in new member orientation. • **Fax education on timely filing requirements** to providers/groups with balance billing grievances associated with untimely claims filing. • **Provide general education** on balance billing rights to members at community events.

PIP	Interventions
	• **Annual member educational mailing** targeted to Medicaid members with dual coverage (i.e., Medicaid and Medicare) on the importance of providing correct health insurance information to healthcare providers and managing multiple health insurance cards. • **Member educational mailing** targeted to Medicaid members with dual coverage (i.e., Medicaid and Medicare) on the importance of providing correct health insurance information to healthcare providers and managing multiple health insurance cards who filed a balance billing member grievance in the previous quarter.

PIP: Performance Improvement Project.

Four MCOs engaged in a Core Medicaid PIP relating to Increasing Immunizations for Adolescents (IMA). **Table 17** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 17: PIP Interventions Summary 2024–2025 for IMA: Increasing Immunizations for Adolescents

PIP	Interventions
ABHNJ - Increasing IMA Combination 2 Vaccinations and Well Child Visits	• **Educate members about the HPV vaccine** by SMS through mPulse. • **Educate members about importance of visits** and safety of vaccines vaccine by IVR and SMS through mPulse. Outreach occurs on an annual basis during the month of the member's birthday. • **Educate members about importance of visits** and safety of vaccines through mailers that include information about immunization schedule awareness and the importance of immunizations sent out during the members birthday month. • **Identify members noncompliant** with age appropriate immunizations or well child visits assigned to targeted practices and conduct member outreach to educate members and assist with appt scheduling. • **Work with targeted practices** to schedule "clinic day" events for nonadherent children to get adolescent well-care visits/immunizations. • **Plan to give the targeted practices** monthly/quarterly Gaps in Care reports which identify adolescents assigned to the practice who have not had age appropriate immunizations or well child visits. Combination vaccines are broken down to individual vaccines that make up the combination including missed HPV vaccines. These reports are transmitted to all primary care offices for educational purposes. Reductions in nonadherent members will be monitored through the Gaps in Care reports. • **Plan to give quarterly roster** to targeted practices identifying new members on panel for outreach for a baseline appointment. Appointments to be monitored through quarterly claims data for an initial appointment and will be reported within the quarter that the claim is received.
HNJH - IMA Combo-2 PIP - Core Medicaid Membership	• **Quarterly printed educational** materials regarding the importance of annual PCP well visits mailed to the parent or guardian of all members between the ages of 8 through 12 years and reside in Sussex, Warren or Salem counties during the measurement year who did not have an annual well visit. Education would be personalized to include the member's assigned PCP, their PCP's contact information, information on transportation, the importance of annual visits, and preventive health screenings. • **Quarterly printed educational materials** mailed to the parent or guardian of any member turning 9 or 11 years of age within 3 months during the measurement year and reside in Sussex, Warren or Salem counties. The mailer would be personalized to each member outlining any upcoming immunizations for which their child will soon be

PIP	Interventions
	eligible. • **Tri-Annual educational** electronic articles published into the Medicaid member newsletter. • **Annual printed educational materials**, (Wellness Visit Flyer and HPV Flyer) mailed to the parent or guardian of any member between 12-13 years of age who are non-compliant with the HPV vaccine. • **Annual printed educational materials** (HPV Postcard) mailed to the parent or guardian of any member 12-years and turning 13-years during the measurement year. • **Quarterly IMA-Combo 2 educational Webinar** for providers in Sussex, Warren and Salem counties. • **Tri-Annual educational articles** published into the Medicaid provider electronic newsletter. • **Monthly Gap list to providers** in Sussex, Warren and Salem counties in the HNJH Rewards and Recognition (R&R) program for the IMA-Combo 2 vaccination status in Q2 through Q4 of the measurement year. • **Quarterly FAX blast** to providers not enrolled in the R&R program that have panels with members between 9-13 years of age residing in Sussex, Warren or Salem counties with educational information specific to the IMA-Combo 2 vaccination. • **Quarterly outreach to providers** with members between 9-13 years of age in their panels residing in Sussex, Warren or Salem counties on initiating office "standing orders" for the HPV vaccine.
UHCCP - Immunizations for Adolescents (IMA)	• **Outreach to the parents/ caregivers** of members assigned to Practices 1, 2 and 3, to remind them to schedule their appointments, and to provide education on importance of preventive care (well child exam and adolescent vaccinations). • **Provide case management referral** to parents/caregivers of members assigned to Practices 1, 2 and 3 who indicated that social determinant of health (SDOH) issue (relating to food, housing, or transportation) presents a barrier to bringing their child for the WCV. • **Monthly practice outreach/education** by the Health Plan to the staff at Practices 1, 2 and 3 regarding remediating gaps for WCV and IMA Combo 2 using the Time Sensitive Measure report and assuring the Staff has proper in office messaging and handouts for member regarding IMA combo 2. • **Educational materials provided** to parents /caregivers of members assigned to Practices 1, 2 and 3 (3 months prior to their 10th -13th birthday) to reinforce the importance and recommended timing of the adolescent well visit and associated IMA vaccinations.
WPNJ - Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance	• **Targeted education for pediatricians** and family practice physicians related to adolescent HEDIS measures and correct coding for administration of immunizations. • **Targeted education for pediatricians** and family practice physicians related to available provider quality incentives for immunizations. • **Targeted HPV text message** to parents/guardians of members identified as not receiving HPV immunization or incomplete HPV vaccine series. • **Tracking of # of members** that received an HPV immunization or completed the HPV vaccine series after receiving a text. • **Tracking of # of members** that received an HPV immunization or completed the HPV vaccine series after receiving a text.

PIP	Interventions
	• **Tracking the # of members** who received an HPV vaccine after receiving an educational mailing "(HPV) Human Papillomavirus Should My Child Get the HPV Vaccine". • **Promotion of new online** Appointment Assistance Request feature on the member website via social media. • **Tracking the # of appointments** made for adolescent members ages 9-13 utilizing the Appointment Assistance Request feature on the member website. • **Barrier discussions and education** with provider groups with highest number of adolescent members ages 9-13 missing both well-child visit and IMA Combo 2 vaccines.

PIP: Performance Improvement Project.

All five MCOs engaged in an MLTSS PIP relating to Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS HCBS Population. **Table 18** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 18: PIP Interventions Summary 2024–2025 for Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS HCBS Populations

PIP	Interventions
ABHNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Increase documented interactions** between BH UM and MLTSS CM at least 3 times before member is discharged to ensure outpatient follow-up needs are met. Documented interactions can be defined as: communication via telephone, email, or in-person after admission, following concurrent review and at the time of discharge, participation in a BH UM rounds. • **BH UM will send** the discharge clinical information to the MLTSS CM within 48 hours following receipt from the hospital. • **Formalized information** gathering for social determinants of health for all members will occur during the BH UM discussions to facilitate discharge planning. • **MLTSS HCBS members** with a behavioral health inpatient admit that have an identified SDoH issue or have been identified as being at high risk for nonadherence to discharge plan (based on the *Immediate Outreach Trigger List*) will receive outreach post discharge by their MLTSS CM within 48 business hours of the BH UM receiving discharge information from the facility to troubleshoot and resolve any barriers to attending behavioral health follow-up. • **BH UM will coordinate** the scheduling of a MH f/u visit pre-discharge. If appt is scheduled >7 days from discharge, BH UM will educate providers regarding BH appointment standards. If the scheduled appointment is not shared before discharge or the appointment is outside of the 7 and 30 day timeframe, the MLTSS Care Manager will work with the member to get an appointment scheduled within the appropriate timeframe. **MLTSS care manager** will coordinate the scheduling of a BH f/u visit post-discharge if an appointment is not scheduled.
FC/WCHP-Improving Coordination of Care and Ambulatory Follow-up	• **Fidelis Care to coordinate provider** training on a quarterly basis on the identification of factors impacting member follow up and adherence to treatment protocols among members with a behavioral health diagnosis. • **Screening for SDoH factors** that present barriers for follow up treatment for members who have been recently discharged from an acute care setting with behavioral health diagnosis.

PIP	Interventions
After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Track referrals made** to community based MLTSS services for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Track referrals made** to community based resources for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Outreach members** identified with a recent behavioral health acute inpatient discharge and complete the Initial Contact for Behavioral Health Discharges Screening tool. • **Document member preference** of either in-person or telehealth follow up visits with primary care/specialist. Track utilization of telehealth/in person for 30-day follow-up visit among the members meeting criteria for the project.
HNJH - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **The MLTSS care manager** will review generalized educational material with the member (regarding the stigma of mental illness, the importance of treatment and where to find help) emphasizing the importance of routine wellness visits to members with a HEDIS defined MH diagnosis. • **The CM will outreach** to engage and collaborate with any identified personal representatives, assisted living staff or house managers (boarding homes/group homes) as possible, regarding the importance of post facility ambulatory care within 10 calendar days of hospital discharge. • **The CM will outreach** the member and provide generalized education emphasizing the importance of routine wellness visits to members with a HEDIS defined MH diagnosis. • **The CM will escalate and refer** any member with a mental health related hospital readmission during the review period for the bi-weekly "Readmission Rounds Meeting" to be further reviewed by the MLTSS and BH Interdisciplinary Team meeting. • **The MLTSS care manager** will conduct outreach within 3 business days of an identified inpatient mental health related hospital discharge, this will allow the care managers to address the members' needs with mental health related conditions sooner than the contractual timeframes. In addition, the MLTSS care manager will conduct a 30-day pledge post hospital, which includes a Face-to-Face visit within 10 calendar days and weekly telephonic outreach. • **The Outpatient mental health care providers** for MLTSS members with HEDIS defined mental health related dx and acute mental health related hospital discharge, will be outreached post hospital discharge. Outreach to include; offer for assistance with care coordination and confirmation of post facility follow-up appointment, share MLTSS CM contact information and request for outreach with member concerns or non-adherence with appointments. • **The MLTSS team will review** "claim discrepancy" twice monthly to help identify any previously unidentified hospitalizations covered by another payor, i.e., Medicare or other commercial plans and outreach member for post facility outreach. • **Inpatient mental health providers** will be educated on the importance of timely notification of inpatient admissions regardless of payor and reeducated on use of the Horizon Alert forms to help support and improve collaboration and the success of discharge planning. • **The MLTSS Care Management** and Behavioral Health teams will assist with coordinating follow up care appointment for members following mental health related hospital discharge.

PIP	Interventions
	• **MLTSS members with HEDIS** defined mental health related diagnosis and an acute mental health related hospital discharge, will be provided with education on use and availability of telehealth appointments during the post facility contact.
UHCCP - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Behavioral health advocate care manager** will make at least 3 attempts to contact the discharged member to establish care management services. • **The BHA Care Manager** will collaborate with the MLTSS care manager to ensure the member has been contacted and is engaging in Behavioral Health care management. • **Behavioral Health Advocate Care Manager** and MLTSS care manager collaborate with the hospital discharge planner to make sure that member's follow up appointment is scheduled prior to member's discharge, for the date within 30 days of discharge. • **Behavioral Health Advocate Care Manager** follows up that an appointment with a behavioral health provider is scheduled for the date within 30 days of discharge and member is aware of the scheduled appointment. • **Member's Behavioral Health Advocate Care manager**, MLTSS Care Manager and Behavioral Health Medical Director hold an interdisciplinary team meeting to discuss the recently admitted member's plan of care within 1 week of member's inpatient admission notification. • **Behavioral Health Advocate Care Manager** provides a reminder phone call to the member 24-48 hours prior to the follow up appointment. • **Behavioral Health Advocate Care Manager** follows up with member after the scheduled appointment to determine if the follow up appointment was completed. • **Behavioral Health Advocate Care Manager** follows up with member's provider after the scheduled appointment to determine if the follow up appointment was completed. • **If member did not complete their appointment**, Behavioral Health Advocate Care Manager reschedules the missed appointment. • **If the Behavioral Health Advocate Health Care manager** determines that lack of transportation prevents the member from completing the follow up appointment, they advise/assist the member in utilizing telehealth to complete a follow up visit with a mental health practitioner. • **If the Behavioral Health Advocate Health Care manager** determines that lack of transportation prevents the member from completing the follow up appointment, they assist the member in arranging medical transportation to complete a follow up visit with a mental health practitioner. • **Behavioral Health Advocate Care Manager** and MLTSS care manager follow up that member who declines to complete a follow up visit with a mental health provider within 30 days of discharge completes a follow up visit with a primary care provider within 30 days of discharge.
WPNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS	• **Behavioral health team** to contact mental health provider to schedule/reschedule follow-up appointment for MLTSS HCBS members (within 7 days post discharge) • **Behavioral health team** to contact mental health provider to schedule/reschedule follow-up appointment for MLTSS HCBS members (within 30 days post discharge) • **Face-to-face or telephonic visits** by a Behavioral Health Case Manager with MLTSS HCBS members discharged from the hospital • **Implementation and promotion** of provider incentive for FUH Compliance (7- day follow up) • **Implementation and promotion** of provider incentive for FUH Compliance (30- day follow up)

PIP	Interventions
Home and Community Based (HCBS) Populations	

PIP: Performance Improvement Project; MLTSS: Managed Long-Term Services and Supports; BH: Behavioral Health; CM: Care Management/Care Manager; UM: Utilization Management; SDoH: Social Determinants of Health; MH: Mental Health; FUH: Follow-Up after Hospitalization; HEDIS: Healthcare Effectiveness Data and Information Set.

All five MCOs engaged in an MLTSS PIP relating to Improving the Number of 10-Day Post Discharge Visits with Assessment for the MLTSS HCBS Population. **Table 19** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 19: PIP Interventions Summary 2024–2025 for Improving the Number of 10-Day Post Discharge Visits with Assessment for the MLTSS HCBS Population.

PIP	Interventions
ABHNJ - Increasing the Number of 10-day Post-Discharge Visits with Assessment for the MLTSS Population	• **The Plan will work with New Jersey Health Information Exchange Network** to get real-time information on member discharges. • **After being informed that a MLTSS HCBS member has been admitted to an inpatient hospital bed**, the assigned MLTSS Care Manager will outreach the member while they are still in the hospital to schedule the follow up visit and assist the member with scheduling and organization of other post discharge appointments if needed. • **The Plan will meet with the top 5 hospitals** with the highest number of MLTSS HCBS on a quarterly basis to discuss improving communication around timely notification of planned and actual discharge dates and facilitate care manager contact with the member prior to discharge to schedule the assessment. • **The Plan will increase communication between MLTSS Care Management and the Utilization Management Department** by having UM email the MLTSS CM both when one of their members is admitted and then again when UM receives discharge notification on that member. In addition, medical directors will inform MLTSS Care Management of a discharge date when they learn during a peer to peer that an observational stay transitioned to an inpatient admission and the member was discharged.
FC/WCHP-Improving Timely 10-day Post-Discharge Visits from The Acute Care Setting with Assessment by The Care Manager in The MLTSS HCBS/FIDE	• **Care Management will conduct a 10-day post discharge visit** that will include a comprehensive assessment to address member needs as well as SDOH factors. • **Track the number of 10-day** post discharge visits that were conducted timely. • Track the number of members that completed the assessment tool during the 10- day post-discharge visit. • **To address MLTSS services/SDOH** needs that were identified during the assessment at the post-discharge visit. • **Need to enhance existing assessment tool** post discharge acute setting. • **Provide virtual ongoing education to service providers** (medical day care (MDC) and personal assistant care (PCA)) of the importance of notifying the plan when a member is hospitalized during networks quarterly required provider training. • **Provide ongoing education to members** and their families during face-to-face visits. • **Collaborating with members** and formal service providers to educate the importance of scheduling a face-to-face visit within 10-days of discharge to coordinate services,

PIP	Interventions
SNP Population	reconcile medications, coordinate follow-up needs and assess the need for additional services.
HNJH – MLTSS 10-Day Post-Discharge Visits with Assessment	• **The MLTSS Care Manager will review generalized educational material** with members that haven't had a wellness visit in 12 months emphasizing the importance of routine wellness visits and preventative care. • **The MLTSS Care Manager will conduct outreach** within 10 business days of an identified inpatient hospital discharge. In addition, the MLTSS Care Manager will conduct a 30-day pledge post hospital, which includes a face-to-face visit within 10 business days and weekly telephonic outreach each week for 4 consecutive weeks. • **If the member refuses to complete the Face to Face (F2F)** within 10 business days, the CM will offer a telephonic assessment in lieu of an F2F assessment. • **The MLTSS Care Management will assis**t with coordinating follow-up care appointments and send appointment reminders to members following a hospital discharge. • **The Outpatient providers for MLTSS members** with IP hospital discharge, will be outreached post hospital discharge. Outreach to include offer for assistance with care coordination and confirmation of post facility follow-up appointment, share MLTSS CM contact information and request for outreach with member concerns or non-adherence with appointments. • **Care Managers will educate members**, and coordinate care for medical resources that members can utilize in the comfort of their home such as PT/OT acquire needed medical equipment, skilled nursing visits, and/or PCA services in lieu of being discharged to a nursing home.
UHCCP - Improving the Rate of Timely 10-Day Post-Discharge Visit with Assessment for MLTSS Members	• **MLTSS Care Managers will receive a daily report** of all admissions and discharges that took place in the past 2 weeks via email in order to notify them of current admissions and recent discharges. (*This is not an automated report. This intervention ensures that the person in charge of the report is running and distributing this report daily. The number of reports intended to be emailed equals the number of business days in the measurement period).* • **MLTSS Care Managers document** all outreach attempts to schedule the face-to-face post-hospitalization assessment. • **Charts are audited monthly** by the MLTSS Managers of Care Management. If the post-hospitalization face-to-face visit with assessment or telephonic post-hospitalization assessment was not completed due to the Care Manager not following the post-hospitalization follow-up process, the Care Manager is re-educated on the follow-up process by their manager. • **MLTSS Care Management supervisors monitor** the daily discharge report. MLTSS Care Management supervisors send a weekly reminder email to their team of MLTSS Care Managers if their members were listed on the discharge report in the past week. The purpose of the email is to remind the MLTSS Care Managers to schedule and complete the post-discharge visit with assessment. • **The MCO monitors the rate** of eligible discharges for which an in-person visit with assessment, or a telephonic assessment was completed within 10 business days post-discharge. Rates are calculated monthly, and aggregate rates are calculated quarterly, to determine the effectiveness of the interventions. These rates are ultimately reflected in the Performance Indicators.

PIP	Interventions
	• **If member refuses to have an in-person meeting** in the required time frame, the CM will document the reason for refusal and complete the post-hospitalization assessment over the phone.
WPNJ - Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members	• **Care manager to MLTSS membership ratios** is reviewed on a monthly basis to identify care manager position need, if any. • **The care manager will conduct post-hospitalization** telephonic assessment within 10 business days for members who decline a post-hospitalization face-to-face visit. • **The Medical Management Specialists** will conduct a telephonic outreaches to hospitalized members on the day of discharge and will enter the discharge date on the SharePoint site. • **Implement automatic SharePoint** notifications to the care manager (and clinical manager) upon member's discharge from the hospital. • **Investigate and address** the reasons why members refuse both face-to-face visits and telephonic outreach. • **Implement additional questions** specific to post hospitalization follow-up by the care manager to the member survey.

PIP: Performance Improvement Project; MLTSS: Managed Long-Term Services and Supports; BH: Behavioral Health; CM: Care Management/Care Manager; UM: Utilization Management; SDoH: Social Determinants of Health; MH: Mental Health.

Protocol 2: Validation of Performance Measures (PMs)

Objectives

The NJ FamilyCare Managed Care Contract Article 4.6.2.P requires NJ FamilyCare MCOs to report annually on HEDIS PMs. As a part of its EQR responsibilities, IPRO reviewed the reported rates and validated the methodology used to calculate those measures. In addition, DMAHS requires the MCOs to report NJ-specific PMs and Core Set Measures annually.

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

Technical Methods of Data Collection and Analysis

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS FAR prepared by an NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable **(Table 20).** In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used, and medical record review procedures relevant to the calculation of the hybrid measures.

Description of Data Obtained

The five MCOs with performance data for MY 2024 (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) reported HEDIS MY 2024 data. The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications, and there were no data collection or reporting issues identified by the MCOs' independent auditors.

IPRO reviewed each of the NJ MCOs' HEDIS MY 2024 FARs to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 20).**

Table 20: MCO Compliance with Information System Standards – MY 2024

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

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

Information Systems Capabilities Assessments

Pursuant to the release of the updated EQRO Protocols by CMS in 2023, DMAHS requested IPRO to conduct an ISCA review in 2024 for all NJ MCOs. IPRO worked with DMAHS to customize the ISCA worksheet of the *CMS External Quality Review (EQR) Protocols* published in February 2023. In addition to customizing the ISCA survey tool for NJ's Medicaid products, including MLTSS, the ISCA was also modified to include questions relating to the NJ FIDE SNP. Additional questions were included related to the annual NJ State-specific PMs, HEDIS ECDS measures and race and ethnicity categories, and encounter data submissions to the State.

The MCO's information system assessment reviews included:

- Data Integration and Systems Architecture,
- Membership Data Systems and Processes,
- Claims Data Systems and Processes,
- Performance Measure Reporting,
- Race and Ethnicity and ECDS Measures,
- Provider Data Systems and Processes,
- Provider Network Adequacy,
- Oversight of Contracted Vendors,
- Grievance Systems, and
- Encounter Data Submissions to State.

At the conclusion of the ISCA review, IPRO compiled and analyzed the information gathered through the preliminary ISCA review and from the MCO staff interviews to produce individual MCO ISCA reports. A statement of findings about the MCO's IS review and an assessment level were assigned in MCO reports. During the 2024 ISCA review, the MCOs were assessed on the topics in **Table 21**. All NJ MCOs met eight of the nine assessment rating standards. Four MCOs (ABHNJ, FC/WCHP, HNJH, and UHCCP) met the ninth assessment rating standards, while one (WPNJ) received a partially met. The assessment for the submission to Transformed Medicaid Statistical Information System (T-MSIS) was not applicable to NJ MCOs since the MCOs submit encounter data to the state.

Table 21: 2024 ISCA Findings by MCO

Assessment Topic	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Completeness and accuracy of encounter data collected and submitted to the State	Met	Met	Met	Met	Met
Validation and/or calculation of performance measures	Met	Met	Met	Met	Met
Completeness and accuracy of tracking of member grievances	Met	Met	Met	Met	Met
NJ Appointment Assistance Form	Met	Met	Met	Met	Met
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	Met	Met	Met	Met
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	Met	Met	Met	Met
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	Met	Met	Met	Met

Assessment Topic	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Validation and/or calculation of network adequacy reports	Met	Met	Met	Met	Met
Identification and reporting of NCQA's and CMS's race and ethnicity categories	Met	Met	Met	Met	Partially Met

MCO: Managed Care Organization; NJ: New Jersey; NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services.

HEDIS MY 2024 Performance Measures

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

Conclusions and Comparative Findings

All MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ) provided audited HEDIS rates for MY 2024. For most measures, if the measure's rate was higher than last year, it was considered an improvement. For inverse measures, however, it was considered an increase in performance if the measure's rate was lower than last year. A more than 5 percentage points change is considered a significant change.

All five MCOs reported the rates for all breakouts as required by DMAHS.

Overall, most HEDIS measures remained constant from MY 2023 to MY 2024. For HEDIS measures that NJ prioritizes and includes on a HEDIS grid, rates below the 10th percentile and above the 75th percentile for MY 2024 are noted below.

Comparisons to HEDIS Percentiles

New Jersey Medicaid Average (Weighted) Comparison to NCQA Percentiles

Rates below the 10th percentile:

a. Appropriate Treatment for Upper Respiratory Infection (URI) [18-64 Years]
b. Depression Remission or Response for Adolescents and Adults (DRR-E) [Follow-Up - 45-64]
c. Follow-Up After Emergency Department Visit for Substance Use (FUA) [13-17 years - 30 Day Follow-Up]
d. Follow-Up After Hospitalization for Mental Illness (FUH) [6-17 years - 30-Day Follow-Up, 6-17 years - 7-Day Follow-Up]
e. Initiation and Engagement of Substance Use Disorder Treatment (IET) [Total - 13-17 Years Engagement]
f. Postpartum Depression Screening and Follow-Up (PDS-E) [Follow Up]
g. Prenatal Depression Screening and Follow-Up (PND-E) [Follow Up]

Rates above the 75th percentile:

a. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
b. Adults' Access to Preventive/Ambulatory Health Services (AAP) [65+ Years]
c. Asthma Medication Ratio (AMR) [5-11 Years, 19-50 Years, 51-64 Years, Total]
d. Child and Adolescent Well-Care Visits (WCV) [3 - 11 years, 12 - 17 years, 18 - 21 years & Total Rate]

e. Childhood Immunization (CIS) [Combination 10]
f. Childhood Immunization Status (CIS-E) [Influenza]
g. Controlling High Blood Pressure (CBP)
h. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) [Follow Up - 65+]
i. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)
j. Follow-Up After Emergency Department Visit for Mental Illness (FUM) [18-64 years - 7-Day Follow-Up, Total - 7 Day Follow-Up]
k. Immunizations For Adolescents (IMA) [Combination 1, Meningococcal, Tdap/Td]
l. Immunizations for Adolescents (IMA-E) [Meningococcal, Tdap, Combo1]
m. Initiation and Engagement of Substance Use Disorder Treatment (IET) [Alcohol - 18-64 Years Initiation, Alcohol - 18-64 Years Engagement, Other - 18-64 Years Initiation, Other - 18-64 Years Engagement, Total - 18-64 Years Initiation, Total - 18-64 Years Engagement, Opioid - 65+ Years Engagement, Other - 65+ Years Engagement, Total - 65+ Years Engagement, Total - Total Years Engagement]
n. Kidney Health Evaluation for Patients with Diabetes (KED) [65–75 years]
o. Lead Screening in Children (LSC)
p. Oral Evaluation, Dental Services (OED) [3-5 Years, 6-14 Years, 15-20 Years, Total]
q. Unhealthy Alcohol Use Screening and Follow-Up (ASF-E) [Screening - 65+]
r. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) [1-11 Years, Total]
s. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) [BMI percentile: 3-11 Years & Total, Counseling for Nutrition: 3-11 Years, 12-17 Years & Total, Counseling for Physical Activity: 3-11 Years, 12-17 Years & Total]
t. Well-Child Visits in the First 30 Months of Life (W30) [Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)]

IPRO aggregated the MCO rates for the 55 measures included in the NJ Medicaid HEDIS grid and calculated weighted statewide averages to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. HEDIS rates produced by the MCOs were also reported to the NCQA. Complete audit review tables (ARTs) for each MCO are provided in **Appendix A: January 2025–December 2025 NJ MCO-Specific Review Findings.**

For this report, the MCOs' reported rates were compared to the NCQA HEDIS MY 2024 Quality Compass® national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA HEDIS MY 2024 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles **(Table 22**).

Table 22: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 2023 Quality Compass National Percentiles
Red	Below 10th Percentile
Orange	Between 10th and 25th Percentile
Yellow	Between 25th and 50th Percentile
Green	Between 50th and 75th Percentile
Blue	Above 75th Percentile
Purple	No percentiles released by NCQA

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

HEDIS data presented in this section include: Effectiveness of Care, Overuse/Appropriateness, Access/Availability of Care, Utilization and Risk Adjusted Utilization measures. **Table 23** displays the HEDIS PMs for MY 2024 for all MCOs and the NJ Medicaid Average. The Medicaid average is the weighted average of all MCO data.

Table 23: HEDIS MY 2024 Performance Measures

HEDIS MY 2024 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Childhood Immunization (CIS)						
Combination 3	57.66%	65.21%	68.61%	59.85%	63.75%	65.60%
Combination 7	48.42%	51.34%	56.45%	45.26%	49.15%	52.75%
Combination 10	29.93%	35.28%	36.50%	29.93%	30.41%	34.00%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months (6 or more visits)	57.78%	54.00%	59.06%	56.67%	58.07%	58.26%
Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	74.60%	78.81%	77.89%	75.97%	79.61%	77.68%
Child and Adolescent Well-Care Visits (WCV)						
3 - 11 years	68.43%	73.74%	72.70%	71.15%	73.56%	72.37%
12 - 17 years	60.36%	67.02%	66.49%	65.14%	66.20%	65.98%
18 - 21 years	37.87%	45.07%	44.61%	45.68%	43.15%	44.45%
Total Rate	62.33%	67.63%	66.57%	65.22%	67.34%	66.26%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI percentile - 3-11 Years	89.96%	91.21%	92.41%	88.70%	89.63%	91.18%
BMI percentile - 12-17 Years	92.42%	87.68%	88.42%	90.06%	90.07%	89.05%
BMI percentile - Total	90.75%	90.02%	90.83%	89.29%	89.78%	90.37%
Counseling for Nutrition - 3-11 Years	82.08%	86.81%	86.21%	79.57%	83.70%	84.46%
Counseling for Nutrition - 12-17 Years	81.06%	78.99%	85.26%	84.53%	85.82%	84.84%
Counseling for Nutrition - Total	81.75%	84.18%	85.83%	81.75%	84.43%	84.64%
Counseling for Physical Activity - 3-11 Years	79.21%	83.88%	78.62%	78.26%	81.85%	79.22%
Counseling for Physical Activity - 12-17 Years	82.58%	79.71%	78.95%	81.77%	85.82%	80.45%
Counseling for Physical Activity - Total	80.29%	82.48%	78.75%	79.81%	83.21%	79.72%

HEDIS MY 2024 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Immunizations For Adolescents (IMA)						
Meningococcal	82.73%	90.27%	92.70%	89.05%	89.54%	91.14%
Tdap/Td	84.91%	93.67%	94.65%	92.70%	94.16%	93.82%
HPV	29.44%	28.95%	35.77%	33.33%	28.71%	33.98%
Combination 1	81.75%	89.29%	92.46%	88.56%	89.29%	90.79%
Combination 2	28.22%	27.25%	35.52%	31.87%	27.49%	33.28%
Lead Screening in Children (LSC)	77.62%	84.43%	80.90%	77.13%	82.48%	80.49%
Cervical Cancer Screening (CCS)	53.53%	57.42%	60.80%	59.85%	64.48%	60.46%
Chlamydia Screening (CHL)						
16-20 Years	64.63%	61.65%	55.56%	61.64%	57.29%	57.68%
21-24 Years	67.98%	63.99%	69.82%	67.86%	64.51%	68.34%
Total	66.39%	62.80%	61.80%	64.18%	61.10%	62.45%
Oral Evaluation, Dental Services (OED)						
0-2 Years	21.81%	26.58%	26.93%	22.43%	17.77%	24.38%
3-5 Years	54.33%	61.15%	61.71%	60.16%	58.43%	60.49%
6-14 Years	59.81%	65.51%	67.07%	67.35%	65.64%	66.57%
15-20 Years	42.64%	50.26%	51.89%	54.05%	48.88%	51.59%
Total	49.00%	55.90%	57.77%	58.16%	53.77%	56.85%
Topical Fluoride for Children (TFC)						
1-2 Years	14.62%	18.30%	16.38%	17.63%	17.33%	16.71%
3-4 Years	23.45%	27.57%	26.12%	30.54%	22.73%	26.19%
Total	19.09%	23.05%	21.43%	24.07%	20.07%	21.57%
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	68.87%	71.72%	77.50%	78.18%	75.58%	76.58%
45-64 Years	80.26%	87.54%	86.29%	87.80%	84.57%	86.12%
65+ Years	87.91%	88.88%	94.15%	95.50%	94.05%	93.20%
Total	75.18%	82.70%	81.52%	85.36%	80.67%	81.93%
Asthma Medication Ratio (AMR)						
5-11 Years	59.65%	75.00%	87.08%	61.40%	63.27%	79.70%
12-18 Years	52.17%	83.33%	81.06%	53.11%	59.04%	72.13%
19-50 Years	64.80%	72.07%	79.53%	56.10%	57.61%	72.35%
51-64 Years	77.78%	73.68%	83.82%	57.72%	68.06%	75.69%
Total	66.42%	73.91%	82.34%	56.96%	61.60%	74.66%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
3 months to 17 Years	63.95%	57.60%	61.19%	60.23%	65.49%	61.48%
18 to 64 Years	41.44%	35.06%	34.49%	38.69%	44.37%	36.80%
65+ Years	56.25%	45.15%	30.51%	30.14%	31.37%	35.00%
Total	59.91%	48.32%	51.61%	50.13%	56.80%	51.97%
Appropriate Treatment for Upper Respiratory Infection (URI)						
3 Months-17 Years	92.60%	93.08%	92.23%	90.39%	92.33%	91.93%
18-64 Years	63.82%	57.24%	62.13%	63.52%	67.76%	62.89%
65+ Years	63.08%	63.31%	50.80%	51.20%	50.34%	53.83%
Total	85.29%	81.44%	84.04%	81.92%	86.30%	83.85%
Appropriate Testing for Pharyngitis (CWP)						

HEDIS MY 2024 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
3-17 Years	88.42%	78.70%	74.81%	84.34%	91.38%	80.12%
18-64 Years	66.45%	48.41%	53.21%	62.70%	68.97%	57.34%
65+ Years	33.33%	14.24%	45.37%	36.70%	26.92%	33.11%
Total	82.08%	66.74%	68.26%	78.07%	85.38%	73.34%
Glycemic Status Assessment for Patients With Diabetes (GSD)						
HbA1c Poor Control (>9.0%)[4]	26.28%	21.90%	32.16%	22.87%	28.22%	28.25%
HbA1c Control (<8.0%)	63.02%	70.80%	56.03%	68.61%	65.69%	61.78%
Eye Exam for Patients with Diabetes (EED)	55.23%	60.58%	61.31%	62.76%	50.09%	60.13%
Blood Pressure Control for Patients with Diabetes (BPD)	74.70%	77.37%	74.62%	73.24%	70.56%	74.10%
Kidney Health Evaluation for Patients with Diabetes (KED)						
18–64 years	40.75%	46.76%	46.69%	46.57%	44.22%	46.12%
65–74 years	46.90%	45.37%	61.60%	57.74%	52.82%	55.53%
75–85 years	46.47%	36.95%	59.08%	55.72%	56.23%	52.37%
Total Rate	42.60%	44.77%	48.53%	50.87%	47.12%	48.31%
Controlling High Blood Pressure (CBP)	71.05%	75.43%	69.85%	74.21%	69.59%	71.51%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NA	NA	66.33%	58.49%	NA	62.77%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
21-75 years (Male) - Received Statin Therapy	78.34%	81.30%	84.93%	84.16%	84.86%	84.01%
40-75 years (Female) - Received Statin Therapy	71.65%	78.35%	82.86%	80.70%	80.91%	81.05%
Total - Received Statin Therapy	75.68%	79.93%	84.02%	82.39%	83.14%	82.64%
21-75 years (Male) - Statin Adherence 80%	72.35%	72.50%	76.70%	79.88%	72.09%	76.39%
40-75 years (Female) - Statin Adherence 80%	69.52%	75.55%	76.75%	78.61%	74.46%	76.73%
Total - Statin Adherence 80%	71.29%	73.89%	76.73%	79.24%	73.10%	76.55%
Follow-Up After Emergency Department Visit for Substance Use (FUA)[5]						
13-17 years - 30 Day Follow-Up	NA	NA	20.60%	17.00%	13.33%	18.96%
13-17 years - 7 Day Follow-Up	NA	NA	14.29%	14.00%	10.00%	13.51%
18 and older - 30 Day Follow-Up	41.22%	35.73%	45.65%	44.42%	43.09%	44.37%
18 and older - 7 Day Follow-Up	30.15%	25.30%	34.17%	32.19%	29.70%	32.65%
Total - 30 Day Follow-Up	40.94%	35.12%	44.74%	43.24%	42.45%	43.53%
Total - 7 Day Follow-Up	29.84%	24.92%	33.45%	31.41%	29.28%	32.02%
Follow-Up After Hospitalization for Mental Illness (FUH)[5]						
6-17 years - 30-Day Follow-Up	38.39%	NA	50.82%	NA	58.75%	52.77%
6-17 years - 7-Day Follow-Up	17.86%	NA	19.67%	NA	38.13%	30.15%
18-64 years - 30-Day Follow-Up	42.38%	57.52%	59.19%	53.49%	44.50%	47.53%
18-64 years - 7-Day Follow-Up	22.72%	30.97%	31.89%	32.20%	24.49%	26.34%
65+ years - 30-Day Follow-Up	41.03%	28.57%	56.00%	47.24%	41.67%	45.83%
65+ years - 7-Day Follow-Up	23.08%	22.86%	33.33%	25.98%	25.00%	26.92%
Total - 30-Day Follow-Up	41.96%	50.68%	57.71%	52.62%	47.03%	48.00%

HEDIS MY 2024 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Total - 7 Day Follow-Up	22.28%	29.05%	30.63%	30.98%	26.98%	26.82%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[5]						
6-17 years - 30-Day Follow-Up	63.13%	53.57%	70.57%	62.24%	55.98%	66.91%
6-17 years - 7-Day Follow-Up	50.51%	44.64%	59.69%	50.15%	44.42%	55.74%
18-64 years - 30-Day Follow-Up	55.90%	58.04%	60.49%	61.38%	59.88%	60.07%
18-64 years - 7-Day Follow-Up	43.34%	47.99%	51.53%	48.58%	50.30%	49.96%
65+ years - 30-Day Follow-Up	48.57%	51.61%	52.73%	48.39%	58.00%	51.19%
65+ years - 7-Day Follow-Up	34.29%	38.71%	43.64%	41.13%	46.00%	41.36%
Total - 30-Day Follow-Up	57.22%	56.45%	64.99%	61.09%	58.39%	62.67%
Total - 7 Day Follow-Up	44.58%	46.57%	55.16%	48.84%	48.00%	52.13%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1-11 Years	NA	NA	69.01%	71.43%	54.10%	67.76%
12-17 Years	53.19%	61.29%	74.97%	66.67%	58.33%	70.32%
Total	57.53%	66.04%	73.10%	68.11%	56.99%	69.51%
Use of Opioids at High Dosage (HDO)[4]	11.79%	6.05%	10.33%	8.80%	8.16%	9.51%
Use of Opioids from Multiple Providers (UOP)[4]						
Multiple Prescribers	24.07%	12.96%	18.75%	11.82%	13.97%	16.56%
Multiple Pharmacies	2.91%	1.39%	1.83%	1.43%	2.17%	1.81%
Multiple Prescribers and Multiple Pharmacies	1.94%	0.52%	1.02%	0.79%	1.10%	0.99%
Risk of Continued Opioid Use (COU)[4]						
18-64 years - >=15 Days covered	5.62%	11.69%	5.76%	6.52%	4.99%	6.06%
18-64 years - >=31 Days covered	3.92%	6.72%	3.55%	3.91%	3.58%	3.77%
65+ years - >=15 Days covered	14.80%	23.56%	9.99%	13.15%	15.18%	14.58%
65+ years - >=31 Days covered	11.60%	15.31%	6.82%	7.50%	9.27%	9.16%
Total - >=15 Days covered	6.46%	15.50%	5.93%	7.85%	6.21%	6.90%
Total - >=31 Days covered	4.63%	9.47%	3.68%	4.64%	4.26%	4.30%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	68.91%	75.77%	72.55%	73.77%	77.30%	73.56%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	86.68%	77.73%	88.52%	88.13%	86.49%	87.29%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	64.05%	71.09%	60.87%	66.75%	63.12%	63.05%
Effective Continuation Phase Treatment	49.30%	59.40%	46.52%	49.88%	46.71%	48.15%
Initiation and Engagement of Substance Use Disorder Treatment (IET)						
Alcohol - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Alcohol - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Other - 13-17 Years Initiation	NA	NA	NA	NA	35.71%	CNC
Other - 13-17 Years Engagement	NA	NA	NA	NA	1.02%	CNC

HEDIS MY 2024 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Total - 13-17 Years Initiation	36.84%	NA	NA	NA	34.15%	35.30%
Total - 13-17 Years Engagement	5.26%	NA	NA	NA	0.81%	2.94%
Alcohol - 18-64 Years Initiation	52.81%	40.43%	36.05%	45.97%	48.07%	48.62%
Alcohol - 18-64 Years Engagement	20.81%	10.64%	8.14%	7.26%	19.54%	17.57%
Opioid - 18-64 Years Initiation	69.89%	39.02%	63.83%	48.96%	66.94%	63.97%
Opioid - 18-64 Years Engagement	45.26%	17.07%	45.74%	19.44%	44.31%	40.40%
Other - 18-64 Years Initiation	53.81%	31.25%	39.65%	44.50%	53.02%	50.47%
Other - 18-64 Years Engagement	23.15%	2.50%	8.37%	11.25%	19.60%	18.32%
Total - 18-64 Years Initiation	57.02%	35.71%	48.75%	46.24%	54.56%	53.33%
Total - 18-64 Years Engagement	26.97%	8.33%	23.79%	12.70%	25.50%	23.78%
Alcohol - 65+ Years Initiation	45.28%	32.79%	31.61%	41.31%	34.82%	37.61%
Alcohol - 65+ Years Engagement	9.43%	1.64%	3.23%	6.23%	1.79%	4.67%
Opioid - 65+ Years Initiation	57.41%	14.71%	31.51%	36.31%	71.35%	42.80%
Opioid - 65+ Years Engagement	46.30%	1.47%	15.07%	20.92%	63.16%	29.32%
Other - 65+ Years Initiation	52.94%	13.64%	34.41%	41.29%	27.71%	34.52%
Other - 65+ Years Engagement	17.65%	1.14%	4.30%	17.80%	4.82%	11.03%
Total - 65+ Years Initiation	51.77%	19.35%	32.23%	39.49%	50.27%	38.72%
Total - 65+ Years Engagement	25.53%	1.38%	7.87%	14.99%	31.15%	15.81%
Alcohol - Total Years Initiation	52.12%	36.11%	33.94%	43.40%	46.49%	46.03%
Alcohol - Total Years Engagement	19.40%	5.56%	5.81%	6.69%	17.54%	14.61%
Opioid - Total Years Initiation	68.77%	23.85%	52.91%	42.25%	67.71%	57.84%
Opioid - Total Years Engagement	45.35%	7.34%	35.20%	20.23%	47.87%	37.17%
Other - Total Years Initiation	53.45%	22.02%	38.15%	43.20%	50.25%	47.48%
Other - Total Years Engagement	22.53%	1.79%	7.38%	13.91%	17.38%	16.64%
Total - Total Years Initiation	56.45%	26.49%	42.74%	42.94%	53.39%	49.89%
Total - Total Years Engagement	26.58%	4.42%	17.95%	13.84%	25.22%	21.70%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	86.86%	83.70%	88.65%	84.91%	90.75%	88.13%
Postpartum Care	83.21%	84.18%	83.84%	85.89%	87.59%	84.90%
Plan All-Cause Readmissions (PCR)[6]						
Index Stays per Year - 18-44	12.66%	10.85%	11.87%	11.15%	8.87%	11.41%
Index Stays per Year - 45-54	14.38%	11.90%	13.15%	12.73%	10.99%	12.82%
Index Stays per Year - 55-64	13.37%	12.97%	13.94%	11.87%	10.95%	13.13%
Index Stays per Year - Total	13.20%	11.95%	12.74%	11.69%	10.02%	12.23%
Observed-to-Expected Ratio	1.45	1.26	1.45	1.33	1.16	

[1] WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective 8/1/2023.

[2] Amerigroup NJ began doing business as Wellpoint NJ on 1/1/2024.

[3] New Jersey Medicaid Average is the weighted average of all Managed Care Organization data.

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

[5] FUH and FUM are mental health measures. FUA is a chemical dependency measure. FUH requires full mental health benefits (inpatient and outpatient). FUM and FUA only require partial mental health or chemical dependency benefits.

[6] 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.

Designation NA: Indicates that the MCO had a denominator less than 30.
Designation NR: Indicates that the MCO did not report for the measure.
Designation CNC: Averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.

HEDIS data presented in this section include: Electronic Clinical Data System measures. **Table 24** displays the HEDIS PMs for MY 2024 for all MCOs and the NJ Medicaid Average. The Medicaid average is the weighted average of all MCO data. (Refer to **Table 22:** Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2024 Quality Compass National Percentiles).

Table 24: HEDIS MY 2024 ECDS Performance Measures

HEDIS MY 2024 ECDS Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Childhood Immunization Status (CIS-E)						
DTaP	60.77%	59.69%	68.34%	60.86%	66.08%	65.95%
IPV	73.85%	74.46%	81.35%	73.44%	80.16%	79.14%
MMR	80.65%	82.46%	86.03%	79.41%	84.39%	84.22%
HiB	76.41%	78.46%	83.91%	74.91%	82.95%	81.62%
Hepatitis B	49.37%	61.69%	77.28%	56.55%	74.18%	71.11%
VZV	80.28%	81.92%	85.69%	79.17%	83.83%	83.85%
Pneumococcal Conjugate	55.91%	57.08%	64.97%	57.73%	63.86%	62.75%
Hepatitis A	69.77%	73.54%	78.54%	67.13%	71.62%	74.83%
Rotavirus	56.49%	51.54%	64.25%	53.87%	56.93%	60.40%
Influenza	38.02%	42.15%	46.47%	39.56%	38.72%	43.41%
Combination 3	33.73%	42.77%	55.71%	41.87%	53.24%	51.22%
Combination 7	26.73%	33.00%	45.97%	34.00%	39.25%	41.27%
Combination 10	16.00%	20.85%	28.86%	24.43%	22.99%	26.11%
Immunizations for Adolescents (IMA-E)						
Meningococcal	80.97%	83.36%	88.74%	84.81%	86.95%	87.27%
Tdap	83.35%	88.25%	91.03%	88.12%	90.03%	89.95%
HPV	23.79%	27.54%	34.11%	28.41%	27.03%	31.50%
Combo1	79.52%	81.77%	87.90%	83.60%	85.75%	86.26%
Combo2	21.84%	25.09%	32.76%	26.86%	25.39%	30.02%
Breast Cancer Screening (BCS-E)	49.89%	56.50%	59.50%	65.12%	58.62%	60.15%
Cervical Cancer Screening (CCS-E)	49.50%	52.35%	56.49%	57.71%	59.20%	56.43%
Colorectal Cancer Screening (COL-E)						
46-50 Years	30.88%	30.17%	32.76%	32.95%	28.82%	32.13%
51-75 Years	44.91%	45.26%	50.51%	57.25%	45.61%	50.92%
Total	42.02%	43.31%	46.39%	52.90%	42.00%	47.00%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)						
Initiation	43.16%	43.31%	34.18%	42.21%	37.75%	36.76%
Continuation	53.13%	40.54%	38.50%	47.26%	47.32%	41.81%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)						
Blood Glucose Testing - 1-11 Years	45.00%	40.63%	46.54%	51.16%	53.89%	47.68%
Blood Glucose Testing - 12-17 Years	67.77%	65.17%	66.96%	65.08%	66.58%	66.54%
Blood Glucose Testing - Total	60.22%	54.90%	59.94%	61.02%	62.75%	60.28%
Cholesterol Testing - 1-11 Years	31.67%	28.13%	31.95%	38.61%	44.31%	33.97%
Cholesterol Testing - 12-17 Years	52.07%	49.44%	46.37%	46.33%	50.52%	47.03%
Cholesterol Testing - Total	45.30%	40.52%	41.41%	44.08%	48.64%	42.70%

Blood Glucose and Cholesterol Testing - 1-11 Years	31.67%	28.13%	31.34%	36.30%	43.11%	33.08%
Blood Glucose and Cholesterol Testing - 12-17 Years	51.24%	49.44%	45.65%	45.38%	48.96%	46.20%
Blood Glucose and Cholesterol Testing - Total	44.75%	40.52%	40.72%	42.73%	47.20%	41.84%
HEDIS MY 2024 ECDS Performance Measures	**ABHNJ**	**FC/WCHP[1]**	**HNJH**	**UHCCP**	**WPNJ[2]**	**NJ Medicaid Average[3]**
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)						
Screening - 12-17	0.23%	0.00%	0.01%	0.55%	1.40%	0.28%
Screening - 18-64	9.51%	1.25%	0.07%	1.30%	4.72%	1.50%
Screening - 65+	29.04%	8.66%	0.36%	2.47%	5.39%	5.38%
Screening - Total	10.36%	3.42%	0.06%	1.30%	3.96%	1.55%
Follow Up - 12-17	NA	NA	100.00%	NA	88.00%	71.34%
Follow Up - 18-64	83.47%	100.00%	58.62%	62.50%	54.70%	62.46%
Follow Up - 65+	75.44%	95.45%	31.25%	100.00%	35.71%	74.91%
Follow Up - Total	80.90%	96.77%	51.67%	66.67%	58.33%	59.96%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)						
Time Period 1 - 12-17	0.00%	0.00%	0.08%	0.00%	1.01%	0.14%
Time Period 1 - 18-44	4.83%	0.46%	0.14%	0.00%	2.31%	0.65%
Time Period 1 - 45-64	11.96%	2.60%	0.35%	0.05%	2.85%	1.35%
Time Period 1 - 65+	24.79%	12.49%	1.52%	0.06%	4.29%	4.67%
Time Period 1 - Total	9.72%	6.36%	0.28%	0.03%	2.69%	1.41%
Time Period 2 - 12-17	0.00%	0.00%	0.00%	0.00%	0.95%	0.08%
Time Period 2 - 18-44	6.95%	1.24%	0.06%	0.00%	2.66%	0.81%
Time Period 2 - 45-64	12.96%	2.04%	0.38%	0.00%	4.56%	1.53%
Time Period 2 - 65+	16.36%	5.01%	1.70%	0.00%	5.99%	2.94%
Time Period 2 - Total	9.71%	3.11%	0.25%	0.00%	3.64%	1.27%
Time Period 3 - 12-17	0.00%	0.00%	0.08%	0.00%	1.17%	0.16%
Time Period 3 - 18-44	13.19%	1.52%	0.15%	0.00%	2.06%	1.30%
Time Period 3 - 45-64	23.47%	5.67%	0.44%	0.00%	4.01%	2.50%
Time Period 3 - 65+	22.55%	13.37%	2.39%	0.00%	4.74%	5.12%
Time Period 3 - Total	17.24%	7.90%	0.35%	0.00%	3.03%	2.11%
Time Period All - 12-17	0.00%	0.00%	0.06%	0.00%	1.05%	0.13%
Time Period All - 18-44	8.48%	1.10%	0.12%	0.00%	2.34%	0.93%
Time Period All - 45-64	16.45%	3.47%	0.39%	0.02%	3.82%	1.80%
Time Period All - 65+	21.38%	10.21%	1.86%	0.02%	5.00%	4.25%
Time Period All - Total	12.37%	5.79%	0.30%	0.01%	3.13%	0.14%
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up - 12-17	NA	NA	NA	NA	NA	CNC
Follow-Up - 18-44	NA	NA	NA	NA	NA	CNC
Follow-Up - 45-64	4.76%	NA	0.00%	NA	NA	3.73%
Follow-Up - 65+	NA	NA	NA	NA	NA	CNC
Follow-Up - Total	13.04%	NA	7.32%	NA	NA	10.06%
Remission - 12-17	NA	NA	NA	NA	NA	CNC
Remission - 18-44	NA	NA	NA	NA	NA	CNC

Remission - 45-64	4.76%	NA	0.00%	NA	NA	3.73%
Remission - 65+	NA	NA	NA	NA	NA	CNC
Remission - Total	8.70%	NA	0.00%	NA	NA	5.30%
Response - 12-17	NA	NA	NA	NA	NA	CNC
Response - 18-44	NA	NA	NA	NA	NA	CNC
HEDIS MY 2024 ECDS Performance Measures	**ABHNJ**	**FC/WCHP[1]**	**HNJH**	**UHCCP**	**WPNJ[2]**	**NJ Medicaid Average[3]**
Response - 45-64	4.76%	NA	0.00%	NA	NA	3.73%
Response - 65+	NA	NA	NA	NA	NA	CNC
Response - Total	13.04%	NA	0.00%	NA	NA	6.75%
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)						
Screening - 18-44	5.35%	0.74%	0.00%	0.09%	0.34%	0.43%
Screening - 45-64	11.85%	2.21%	0.00%	0.24%	0.38%	0.95%
Screening - 65+	25.17%	8.74%	0.00%	1.13%	0.50%	3.96%
Screening - Total	9.81%	3.63%	0.00%	0.34%	0.37%	0.98%
Follow Up - 18-44	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Follow Up - 45-64	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Follow Up - 65+	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Follow Up - Total	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Adult Immunization Status (AIS-E)						
Influenza - 19-65	13.62%	16.79%	14.67%	11.14%	14.92%	14.06%
Influenza - 66+	33.40%	28.34%	44.62%	27.08%	44.11%	33.52%
Influenza - Total	16.12%	20.98%	16.16%	14.65%	18.36%	16.42%
TdTdap - 19-65	23.94%	23.70%	35.51%	30.42%	28.61%	32.40%
TdTdap - 66+	14.27%	13.33%	24.55%	20.40%	17.96%	19.17%
TdTdap - Total	22.72%	19.94%	34.96%	28.21%	27.36%	30.79%
Zoster - 50-65	8.83%	10.38%	11.99%	11.79%	7.17%	11.14%
Zoster - 66+	10.15%	10.95%	20.75%	13.79%	9.87%	14.04%
Zoster - Total	9.28%	10.72%	13.42%	12.73%	8.10%	12.09%
Pneumococcal - 66+	35.53%	34.73%	54.67%	41.56%	46.53%	43.19%
Prenatal Immunization Status (PRS-E)						
Influenza	18.58%	14.88%	18.94%	14.84%	13.69%	17.07%
Tdap	41.36%	30.68%	42.03%	33.90%	29.24%	37.76%
Combination	13.64%	9.79%	13.57%	10.08%	8.73%	11.92%
Prenatal Depression Screening and Follow-Up (PND-E)						
Screening	10.23%	0.00%	0.00%	3.29%	7.97%	2.73%
Follow Up	25.00%	NA	NA	50.00%	50.00%	19.71%
Postpartum Depression Screening and Follow-Up (PDS-E)						
Screening	26.84%	0.23%	0.00%	1.89%	11.48%	4.28%
Follow Up	36.36%	100.00%	NA	50.00%	45.45%	23.39%
Social Need Screening and Intervention (SNS-E)						
Food Screening - 0-17	0.00%	0.01%	0.00%	0.00%	1.67%	0.22%
Food Screening -18-64	2.93%	0.04%	0.00%	0.32%	5.35%	0.87%

Food Screening - 65+	2.26%	0.17%	0.00%	1.45%	49.08%	6.35%
Food Screening - Total	1.76%	0.06%	0.00%	0.32%	6.16%	0.92%
Food Intervention - 0-17	NA	NA	NA	NA	4.00%	CNC
Food Intervention - 18-64	46.38%	66.67%	NA	5.65%	6.53%	7.97%
Food Intervention - 65+	33.33%	0.00%	NA	3.57%	6.32%	4.40%
HEDIS MY 2024 ECDS Performance Measures	**ABHNJ**	**FC/WCHP[1]**	**HNJH**	**UHCCP**	**WPNJ[2]**	**NJ Medicaid Average[3]**
Food Intervention - Total	45.33%	33.33%	NA	4.81%	6.21%	5.88%
Housing Screening - 0-17	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%
Housing Screening - 18-64	8.45%	0.91%	0.00%	0.13%	3.08%	0.96%
Housing Screening - 65+	27.11%	5.12%	0.00%	0.95%	47.95%	8.70%
Housing Screening - Total	6.82%	1.70%	0.00%	0.18%	4.26%	1.01%
Housing Intervention - 0-17	NA	NA	NA	0.00%	NA	CNC
Housing Intervention - 18-64	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Housing Intervention - 65+	0.00%	0.00%	NA	0.00%	0.25%	0.03%
Housing Intervention - Total	0.00%	0.00%	NA	0.00%	0.14%	0.02%
Transportation Screening - 0-17	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%
Transportation Screening - 18-64	5.20%	1.49%	0.00%	0.19%	3.12%	0.80%
Transportation Screening - 65+	22.51%	8.75%	0.00%	1.42%	48.73%	9.39%
Transportation Screening - Total	4.69%	2.88%	0.00%	0.26%	4.33%	0.98%
Transportation Intervention - 0-17	NA	NA	NA	NA	NA	CNC
Transportation Intervention - 18-64	0.00%	3.23%	NA	0.00%	0.00%	0.16%
Transportation Intervention - 65+	0.00%	0.00%	NA	0.00%	0.00%	0.00%
Transportation Intervention - Total	0.00%	0.90%	NA	0.00%	0.00%	0.05%

[1] WellCare Health Plans of New Jersey, Inc began doing business as Fidelis Care effective 8/1/2023.
[2] Amerigroup New Jersey, Inc. began doing business as Wellpoint New Jersey, Inc. on 1/1/24.
[3] New Jersey Medicaid Average is the weighted average of all MCO data.

Designation NA: Indicates that the MCO had a denominator less than 30.
Designation NR: Indicates that the MCO did not report for the measure.
Designation CNC: Averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30 (for e-measures, initial population is the eligible population).

MY 2024 New Jersey State-Specific Performance Measures

The MCOs were required to report one NJ-specific measure for their Medicaid population. The MCOs were required to provide member-level files for review and validation.

The required measures were:

- Multiple Lead Testing in Children Through 26 Months of Age (MLT)

The Multiple Lead Testing in Children through 26 Months measure assesses the percentage of children turning 26 months during the MY who had an initial capillary or venous blood lead test between 9 months and 18 months and a second capillary or venous lead blood test between 18 months through 26 months.

Conclusion

All MCOs (Aetna, Fidelis Care, Horizon, United and Wellpoint NJ) reported the required measures for MY 2024. **Table 25** shows state-specific PMs for MY 2024 for all MCOs and the NJ Medicaid average.

Table 25: MY 2024 NJ State-Specific Performance Measures

MY 2024 NJ-Specific Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Multiple Lead Testing in Children through 26 Months of Age (MLT)						
Screening between 9 Months and 18 Months	70.25%	72.05%	68.56%	67.56%	73.25%	69.37%
Screening at 18 Months through 26 Months	53.46%	58.30%	54.02%	54.43%	59.71%	55.12%
Screening between 9 Months and 18 Months AND Screening at 18 Months through 26 Months	42.14%	45.70%	40.94%	41.15%	48.21%	42.38%

[1] WellCare Health Plans of New Jersey, Inc. (WCHP) began doing business as Fidelis Care (FC) effective 08/01/2023.

[2] Amerigroup New Jersey, Inc. (AGNJ) began doing business as Wellpoint NJ (WPNJ) on 1/1/2024.

[3] New Jersey (NJ) Medicaid average is the weighted average of all Managed Care Organization (MCO) data.

Designation NR: Indicates the rate is not reported based on MCO submissions.
Designation NA: Indicates that MCO had a denominator less than 30.
Designation CNC: An unweighted average can only be calculated if 2 or more MCOs have a reportable rate.
MY: measurement year.

MY 2024 New Jersey Core Set Performance Measures

DMAHS reports annually on all mandatory Child and Adult Core Set Measures. There are 15 Core Set Measures on the NJ Specific/Core Set grid.

Seven Child Core Set Measures were reported:
1. Developmental Screening (DEV-CH)
2. Contraceptive Care Postpartum Women Ages 15-20 (CCP-CH)
3. Contraceptive Care All Women Ages 15-20 (CCW-CH)
4. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
5. Oral Evaluation, Dental Services (OEV-CH)
6. Topical Fluoride for Children (TFL-CH)
7. Sealant Receipt on Permanent First Molars (SFM-CH)

Eight Adult Core Set Measures were reported:
1. Diabetes Short-Term Complications Admission Rate (PQI01-AD) – Admissions per 100,000 Member Months
2. Contraceptive Care Postpartum Women Ages 21-44 (CCP-AD)
3. Contraceptive Care All Women Ages 21-44 (CCW-AD)
4. Screening for Depression and Follow-Up Plan: Ages 18 to 64 and Ages 65 and older (CDF-AD)
5. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
6. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD): Ages 18 to 64
7. Concurrent Use of Opioids and Benzodiazepines (COB-AD)
8. Use of Opioids at High Dosage without Cancer (OHD-AD)

Conclusions

All MCOs (Aetna, Fidelis Care, Horizon, United and Wellpoint NJ) reported the required measures for MY 2024.

Table 26 shows the NJ Core Set Measures for MY 2024 for all MCOs and the NJ Medicaid average.

Table 26: MY 2024 NJ Core Set Measures

MY 2024 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Developmental Screening (DEV-CH)						
1 year old	26.80%	27.78%	36.06%	28.04%	19.41%	31.27%
2 years old	38.95%	32.82%	45.11%	43.85%	47.68%	44.46%
3 years old	40.89%	31.19%	39.51%	39.75%	44.64%	40.15%
Total - 1-3 years	36.28%	31.04%	40.50%	38.21%	38.38%	39.20%
Diabetes Short-Term Complications Admission (PQI01) – Admissions per 100,000 Member Months[4,5]						
18 - 64 Years	8.15	11.82	16.18	12.00	7.00	13.56
65 Years and Older	8.56	4.92	8.38	10.48	5.14	8.16
Total	8.21	9.61	15.82	11.70	6.80	12.97
Contraceptive Care - Postpartum Women						

MY 2024 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
(CCP)						
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 3 days	4.17%	5.56%	4.50%	4.64%	5.75%	4.64%
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 90 days	33.33%	50.00%	44.12%	39.07%	37.93%	42.32%
Postpartum Women Ages 15-20 - LARC - 3 days	0.00%	0.00%	0.44%	0.66%	1.15%	0.48%
Postpartum Women Ages 15-20 - LARC - 90 days	13.89%	8.33%	12.05%	15.89%	3.45%	11.88%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 3 days	6.98%	7.79%	9.32%	6.57%	4.59%	7.73%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 90 days	40.50%	40.30%	41.08%	43.11%	42.84%	41.70%
Postpartum Women Ages 21-44 - LARC - 3 days	0.28%	1.00%	0.27%	0.28%	0.28%	0.30%
Postpartum Women Ages 21-44 - LARC - 90 days	9.68%	10.12%	10.03%	9.88%	10.36%	10.05%
Contraceptive Care - All Women (CCW)						
All Women Ages 15-20 - Provision of most or moderately effective contraception	11.87%	9.67%	13.01%	10.24%	10.00%	11.96%
All Women Ages 15-20 - Provision of LARC	1.28%	0.66%	1.23%	0.93%	0.84%	1.11%
All Women Ages 21-44 - Provision of most or moderately effective contraception	21.83%	21.38%	22.72%	22.21%	25.97%	22.92%
All Women Ages 21-44 - Provision of LARC	2.98%	2.85%	3.16%	3.03%	3.87%	3.20%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)						
12-17 Years	1.86%	3.37%	2.34%	2.38%	4.25%	2.56%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)						
18 to 64 Years	3.83%	5.76%	3.70%	3.87%	3.32%	3.80%
65 Years and older	4.89%	8.51%	6.60%	9.81%	5.78%	7.83%
Oral Evaluation, Dental Services (OEV-CH)[6]						

MY 2024 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
< 3 Years	19.85%	24.18%	25.22%	21.22%	16.50%	22.80%
3 to 5 Years	50.69%	58.32%	58.93%	57.62%	55.79%	57.70%
6 to 14 Years	56.91%	62.55%	64.90%	65.05%	63.09%	64.25%
15 to 20 Years	39.82%	46.75%	48.89%	51.09%	45.14%	48.49%
Total: ages to 20 Years	45.94%	52.52%	55.04%	55.53%	50.90%	54.06%
Topical Fluoride for Children (TFL-CH)[7]						
< 3 Years	15.48%	19.25%	18.31%	18.69%	17.69%	18.14%
3 to 5 Years	27.70%	31.72%	32.75%	36.57%	26.61%	32.13%
6 to 14 Years	25.88%	30.08%	32.43%	37.43%	26.86%	32.40%
15 to 20 Years	10.62%	13.49%	16.79%	19.93%	11.84%	16.59%
Total: ages to 20 Years	21.53%	25.15%	26.89%	30.73%	22.25%	26.76%
Sealant Receipt on Permanent First Mol ars (SFM-CH)						
Rate 1 (At Least One Sealant)	48.78%	58.38%	7.62%	63.81%	57.73%	27.79%
Rate 2 (All Four Molars Sealed)	33.79%	39.60%	3.81%	44.43%	37.73%	18.08%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[5]						
18 to 64 Years	55.52%	50.19%	44.75%	42.93%	48.70%	45.86%
65 to 75 Years	60.47%	63.57%	42.53%	50.28%	40.59%	50.25%
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD): Ages 18 to 64						
Total rate (Rate 1)	68.06%	35.80%	47.36%	45.84%	67.84%	58.23%
Buprenorphine (Rate 2)	49.14%	20.99%	26.81%	24.11%	43.29%	36.68%
Oral naltrexone (Rate 3)	2.66%	0.00%	2.50%	1.24%	2.30%	2.06%
Long-acting, injectable naltrexone (Rate 4)	1.81%	0.82%	0.97%	0.77%	1.39%	1.25%
Methadone (Rate 5)	20.72%	15.23%	20.00%	22.01%	26.48%	22.63%
Concurrent Use of Opioids and Benzodiazepines (COB)[5]						
Ages 18 to 64 years	18.36%	20.51%	19.53%	21.48%	20.19%	19.94%
Ages 65 years and above	15.69%	15.71%	17.16%	17.67%	17.03%	17.02%
Total - 18 years and above	17.69%	18.76%	19.32%	20.23%	19.44%	19.40%
Use of Opioids at High Dosage without Cancer (OHD)[5]						
Ages 18 to 64 years	12.39%	9.30%	12.03%	11.93%	8.95%	11.52%
Ages 65 years and above	15.00%	2.18%	7.75%	6.49%	6.56%	6.93%
Total - 18 years and above	13.07%	6.92%	11.65%	10.16%	8.39%	10.69%

[1] WellCare Health Plans of New Jersey, Inc. (WCHP) began doing business as Fidelis Care (FC) effective 8/1/2023.

[2] Amerigroup New Jersey, Inc. (AGNJ) began doing business as Wellpoint NJ (WPNJ) on 1/1/2024.

[3] New Jersey Medicaid average is the weighted average of all Managed Care Organization (MCO) data.

[4] The year-over-year change for PQI-O1 represents a change in utilization per 100,000 member months and is not a percentage point change.
[5] A lower rate indicates better performance.
[6] MY2024 OEV age stratifications are updated from 9 age stratifications and a total rate to 4 age stratifications and a total rate.
[7] MY2024 TFL age stratifications are updated from 8 age stratifications and a total rate to 4 age stratifications and a total rate for each of the three rates.

Designation NA: indicates that MCO had a denominator less than 30.
Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

WYE 2024 MLTSS Performance Measures

Specifications were updated in 2023 for the July 2023–June 2024 measurement period for the PMs listed below. PM #04 was reported on a monthly basis. Four HEDIS measures and two MLTSS-specific measures (PM #47 and PM #54) were reported annually. All other PMs were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2024 (7/1/2023–6/30/2024)

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

The following measures are monitored quarterly and reviewed annually

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

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

Validation Results of WYE 2024 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 reviewed each MCO submission and requested modifications to submissions as necessary. Following validation, data was submitted to the NJ Office of MLTSS Quality Monitoring - Analytics Unit.

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2025, 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 2023–June 2024 measurement period.

The following results are for the July 2023 through June 2024 measurement period:

PM #4: Timeliness of NF Level of Care Assessment by MCO

MCO rates range from 19.1% to 100% from July 2023 to June 2024, and the statewide rates remained steady between 55.2% to 95%

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 99.8% to 100%, and the statewide rates remained steady between 99.9% 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 94.1% to 99.3%, and the statewide rates remained steady between 97.6% to 98.1%.

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 96.5% to 100%, and the statewide rates remained steady between 98.7% to 99.2%.

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 11.4 days to 24 days for the MCO to be aware of the CI. At the statewide level, it took averagely from 16.9 to 17.8 days throughout the measurement year.

PM #20: MLTSS Members Receiving MLTSS Services

The quarterly MCO rates vary from 56% to 82%. The statewide rates remained steady between 72.7% to 73.3%.

PM #20b: MLTSS HCBS Members Receiving MLTSS Services

The quarterly MCO rates vary from 34.0% to 70.9%. The statewide rates remained steady between 59.1% to 60.9%.

PM #21: MLTSS Members Transitioned from NF to Community:

The quarterly MCO rates remain low, from 0.2% to 1.2%, and the statewide rates vary from 0.6% to 0.9%.

PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days

The MCO rates vary from 0% to 20%. The statewide rates range from 4.1% to 10.8%.

PM #26: Acute Inpatient Utilization by MLTSS HCBS Members

The quarterly MCO rates vary from 21.6 to 59.4 utilization per 1000 member months, and the statewide rates range from 38.1 to 41.1 utilization per 1000 member months.

PM #27: Acute Inpatient Utilization by MLTSS NF Members

The quarterly rates vary from 20.6 to 52.7 utilization per 1000 member months, and the statewide rates range from 31.2 to 38.6 utilization per 1000 member months.

PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days

The yearly (1/1/2024 to 12/31/2024 measurement period) rates range from 12.2% to 17.5% and the statewide rate is 13.8%.

PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days

The yearly (1/1/2024 to 12/31/2024 measurement period) rates range from 9.4% to 19.3% and the statewide rate is 10.6%.

PM #30: Emergency Department Utilization by MLTSS HCBS Members

The quarterly rates vary from 36.2 to 91.8 utilization per 1000 member months, and the statewide rates stay relatively stable, from 66.8 to 75.6 utilization per 1000 member months.

PM #31: Emergency Department Utilization by MLTSS NF Members

The quarterly rates vary from 4.2 to 22.9 utilization per 1000 member months, and the statewide rates stay relatively stable, from 11.8 to 14.1 utilization per 1000 member months.

PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members

The specifications for PMs 33, 34, and 41 are being revised and subsequently revalidated. As a result, the associated rates are not reported in the current ATR, and will be reflected in next year's ATR.

PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members

The quarterly rates range from 0% to 71.4%. The statewide rates range from 43.9% to 53.2%.

PM #38: Follow-up After Mental Health Hospitalization for MLTSS NF Members

The quarterly rates range from 0% to 100%. The statewide rates range from 14.3% to 33.3%.

PMs #42: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS HCBS Members

The quarterly rates range from 0% to 100%. The statewide rates vary from 32.8% to 37.9%.

PMs #43: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS NF Members

The quarterly rates range from 0% to 100%. The statewide rates vary from 16.7% to 54.5%.

PMs #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members

The quarterly rates range from 0% to 100%. The statewide rates are relatively stable, varying between 57.1% to 69.1%.

PMs #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members

The quarterly rates range from 0% to 100%. The statewide rates are relatively stable, varying between 22.2% to 64.3%.

PMs #47: Post-hospital Institutional Care for MLTSS HCBS Members

The Yearly rates range from 13.4% to 48.8%. The statewide rate is 38.1%.

PMs #48: Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications

The Yearly rates range from 4.5% to 13.7%. The statewide rate is 8.9%.

PMs #49: Hospitalization for MLTSS NF Members with Potentially Preventable Complications

The Yearly rates range from 3.5% to 8.6%. The statewide rate is 6%.

PMs #50: Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions

The Yearly rates range from 48.9% to 60.1%. The statewide rate is 56.8%.

PMs #51: Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions

The Yearly rates range from 14.1% to 42.3%. The statewide rate is 32.1%.

PMs #52B: Medication review, Care for Older Adults for MLTSS HCBS Members

The Yearly rates range from 71.8% to 91%. The statewide rate is 82.8%.

PMs #52C: Functional status assessment, Care for Older Adults for MLTSS HCBS Members

The Yearly rates range from 47.9% to 99.5%. The statewide rate is 88.1%.

PMs #52D: Pain assessment, Care for Older Adults for MLTSS HCBS Members

The Yearly rates range from 77.9% to 99.3%. The statewide rate is 93.7%.

PMs #53B: Medication review, Care for Older Adults for MLTSS NF Members

The Yearly rates range from 37.5% to 80.1%. The statewide rate is 58.5%.

PMs #53C: Functional status assessment, Care for Older Adults for MLTSS NF Members

The Yearly rates range from 17% to 99.8%. The statewide rate is 79.2%.

PMs #53D: Pain assessment, Care for Older Adults for MLTSS NF Members

The Yearly rates range from 48.4% to 98.5%. The statewide rate is 87.1%.

PMs #54A: New MLTSS members receiving PCA, Medical day, MLTSS services

The Yearly rates range from 75.2% to 92.1%. The statewide rate is 83.8%.

PMs #54B: New MLTSS HCBS members receiving PCA, Medical day, MLTSS services

The Yearly rates range from 59.1% to 82.2%. The statewide rate is 73.4%.

WYE 2025 MLTSS Performance Measures

Specifications were updated in 2024 for the July 2024–June 2025 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. PM #04 was reported on a monthly basis. Four HEDIS measures and two MLTSS-specific measures (PM #47 and PM #54) were reported annually. All other PMs were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2024 (7/1/2024–6/30/2025)

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

The following measures are monitored quarterly and reviewed annually:

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

21. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
22. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
23. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
24. PM #50* – Follow Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
25. PM #51* – Follow Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
26. PM #52* – Care for Older Adults for MLTSS Members (HEDIS COA)
27. PM #53* – Care for Older Adults for NF Members (HEDIS COA)
28. PM #54a* – New MLTSS Members receiving PCA, MDC, and or MLTSS services
29. PM #54b* – New MLTSS HCBS Members receiving PCA, MDC, and/or MLTSS Services
30. PM #56 – Acute Hospital Utilization by MLTSS HCBS Members (HEDIS AHU)
31. PM #57 – Acute Hospital Utilization by MLTSS NF Members (HEDIS AHU)
32. PM #58 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS EDU)
33. PM #59 – Emergency Department Utilization by MLTSS NF Members (HEDIS EDU)

Additionally, the following MLTSS HCBS Quality Measures will be validated for WYE2025:

1. PM #55 – Self-Direction of Services and Supports among Medicaid Beneficiaries Receiving LTSS through Managed Care Organizations
2. PM #60 – Long-Term Services and Supports Comprehensive Assessment and Update for MLTSS Members (HEDIS CAU)
3. PM #61 – Long-Term Services and Supports Comprehensive Care Plan and Update for MLTSS Members (HEDIS CPU)
4. PM #62 – Long-Term Services and Supports Shared Care Plan with Primary Care Practitioner for MLTSS Members (HEDIS SCP)
5. PM #63 – Long-Term Services and Supports Reassessment/ Care Plan Update after Inpatient Discharge for MLTSS Members (HEDIS RAC)
6. PM #64 – Screening, Risk Assessment, and Plan of Care to Prevent Future Falls for MLTSS Members - Screening
7. PM #65 – Screening, Risk Assessment, and Plan of Care to Prevent Future Falls for MLTSS Members - Risk Assessment and Plan of Care
8. PM #66 – Managed Long-Term Services and Supports Admission to a Facility from the Community
9. PM #67 – Managed Long-Term Services and Supports Minimizing Facility Length of Stay
10. PM #68 – Managed Long-Term Services and Supports Successful Transition after Long Term Facility Stay

Validation Results of WYE 2025 MLTSS Performance Measures

The final validation report for WYE 2025 is in progress and will be reflected in next year's ATR.

WYE 2024 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 services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: 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.

IPRO was tasked with assessing the feasibility of producing PM #13 using administrative data rather than Care Management record review. The result of this assessment was the determination that use of administrative data, based on comparison of authorization data and claims data to calculate PM #13, was not feasible. PM #13 is calculated using Plans of Care and claims data. Additionally, IPRO has included Compliance Score Ranges for the delivery of MLTSS Services.

For the measurement period (July 01, 2023–June 30, 2024), random samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The final PM #13 reports were submitted to DMAHS in June 2025.

Plan of Care Services Assessed

MLTSS services assessed in the methodology, derived from the *MLTSS Service Dictionary*, are presented in **Table 27**. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services. As directed by DMAHS, Adult Family Care was excluded from the measurement study.

Table 27: MLTSS Assessment Inclusion Status

MLTSS Services	Included/Excluded
Assisted Living Services/Programs	Included
Chore Services	Included
Community Residential Services	Included
Home Delivered Meals	Included
Medical Day Services	Included
Medication Dispensing Device Monthly Monitoring	Included
PCA/Home-Based Supportive Care	Included
PERS Monitoring	Included
Private Duty Nursing	Included
Adult Family Care	Excluded
Behavioral Health Services	Excluded
Cognitive Therapy	Excluded
Caregiver Participant Training	Excluded
Community Transition Services	Excluded
Non-Medical Transportation	Excluded
Occupational Therapy	Excluded
Physical Therapy	Excluded
Residential Modifications	Excluded
Respite	Excluded
Social Adult Day Care	Excluded
Structured Day Program	Excluded
Supported Day Services	Excluded
Speech, Language, and Hearing Therapy	Excluded
TBI Behavioral Management	Excluded
Vehicle Modifications	Excluded

MLTSS: Managed Long-Term Services and Supports; PCA: Personal Care Assistant; PERS: Personal Emergency Response System; TBI: Traumatic Brain Injury.

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 the expected services was structured on a weekly or monthly basis,[1] 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.

MLTSS Services are often provided on a weekly schedule that is customized for the Member's needs; for instance, a member may require 16 units of Personal Care Assistant (PCA) service per day on weekdays, but only 8 units per day on weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis; the cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday, and any incomplete weeks were dropped from the timeline of expected services. For example, PCA services from September 1, 2023 (Friday) to September 30, 2023 (Saturday) were broken down into 4 complete weeks (i.e., week 10 was September 2 to September 8, . . . week 13 was September 23 to September 29). The first incomplete week of September 1 and final incomplete week of September 30 were dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline.

If there were any blackout periods or planned service discontinuations documented, they were removed from the timeline of expected services at the service level.

IPRO validated the Member-level roll-up file, which showed services provided based on claims for each week in the review period, against the MCOs' claims systems during a review meeting with each MCO. For each service, the timelines were compared to assess the percentage of service delivery for each week/month. The percentage 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 percentage was capped at 100%. This strategy was applied so that, in aggregating services over a span of weeks, claims exceeding expected services in one particular week would not offset deficiencies in delivery of expected services in another week.

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 score at or above 95% for each service documented in the POC for each Member.

Performance Measure Results

As shown in **Table 28**, a total of 30 records were excluded, resulting in a study population of 520 members across all MCOs. Records could be excluded for several reasons; including no POC submitted in the file, POCs submitted did not have the necessary information to produce quantifiable expected services, and POCs contained only documented services that were not evaluated for this measure (e.g., Respite Care or Personal Preference Program).

The total study population was 520, an increase of 63 cases from the 457 cases included in the prior year's measure (**Table 28**). Among the MCOs, study population all increased this year; United study population increased the most by 29 cases, from 66 in the previous year to 95 in the current year. Despite this growth, United still had the lowest sample size among the MCOs, with 95 cases.

[1] The timeline of expected services was structured on a monthly basis for Personal Emergency Response System (PERS) services and Monthly Monitoring of Medication Dispensing Device services. For all other services, the timeline was structured on a weekly basis.

Table 28: WYE 2024 MLTSS Performance Measure #13 Results Summary

MCO	Total Sampled	2024 Total Excluded	2024 Study Population	2023 Total Excluded	2023 Study Population	Change in Study Population from Prior Year
ABHNJ	110	2	108	18	92	+16
FC/WCHP	110	2	108	8	102	+6
HNJH	110	9	101	11	99	+2
UHCCP	110	15	95	44	66	+29
WPNJ	110	2	108	12	98	+10
Total	550	30	520	93	457	+63

MCO: Managed Care Organization.

Table 29 shows compliance at the service level for the individual MCOs, while **Table 30** shows compliance at the service level across all plans. The denominators displayed in **Table 30** and **Table 31** 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 MCOs, the most common MLTSS service was PERS Monitoring; of the 249 members who had PERS Monitoring, 155 (62.2%) received, on average, 95% or more of the planned amount. Across all MCOs, Assisted Living Services/Programs was associated with the highest proportion of members reaching the 95% average threshold of the MLTSS services listed; of the 99 members who had Assisted Living Services/Programs planned, 75 (75.8%) received, on average, 95% or higher of the planned amount.

For services with a denominator greater than or equal to 10 in **Table 31**, improvement was seen from the prior year for the Home Delivered Meals and PCA/Home-Based Supportive Care. Rates with a denominator of less than 10 are listed for reference only. Rates for services for which the denominator is less than 30 should be reviewed with caution. For rates across all plans, the compliance rate of Home Delivered Meals with a denominator of more than 10 increased the most, showing an increase of 14.5 percentage points from 17.9% in the prior year to 32.4% in the current year; the performance of Medical Day Services decreased the most, showing a decrease of 7.1 percentage points from 39.2% in the prior year to 32.1% in the current year.

Table 29: Proportion of MLTSS Services at or above the 95% Average Service Delivery Threshold, by MCO

	ABHNJ				FC/WCHP				HNJH				UHCCP				WPNJ			
Services Evaluated	D	N	2024 %	2023 %	D	N	2024 %	2023 %	D	N	2024 %	2023 %	D	N	2024 %	2023 %	D	N	2024 %	2023 %
Assisted Living Services/Programs	24	14	58.3%[b1]	84.6%	13	5	38.5%[b3]	100.0%[a]	29	28	96.6%[b6]	92.9%	19	16	84.2%[b8]	0.0%[a]	14	12	85.7%[b10]	50.0%[a]
Chore Services																				
Community Residential Services	2	0	0.0%[a]						1	1	100.0%[a]	0.0%[a]	1	0	0.0%[a]					0.0%[a]
Home Delivered Meals	32	12	37.5%[b1]	17.6%	17	2	11.8%[b4]	20.8%	33	8	24.2%	15.8%	29	9	31.0%[b8]	0.0%	28	14	50.0%	26.7%
Medical Day Services	26	8	30.8%[b2]	62.2%	58	21	36.2%	40.4%	15	3	20.0%	25.0%	14	5	35.7%[b8]	0.0%	21	6	28.6%[b11]	28.1%
Medication Dispensing Device Monthly Monitoring				100.0%[a]	4	1	25.0%[a]	40.0%[a]	2	0	0.0%[a]	100.0%[a]	2	2	100.0%[a]					100.0%[a]
PCA/Home-Based Supportive Care	30	10	33.3%[b2]	60.0%	47	11	23.4%[b5]	47.1%	43	23	53.5%[b6]	38.1%	51	20	39.2%[b8]	4.3%	47	19	40.4%	36.7%
PERS Monitoring	54	31	57.4%[b1]	75.0%	61	43	70.5%	69.4%	51	39	76.5%[b7]	85.7%	33	28	84.8%[b9]	88.5%	50	14	28.0%[b11]	32.3%
Private Duty Nursing	3	1	33.3%[a]	0.0%[a]					3	1	33.3%[a]	0.0%[a]	2	0	0.0%[a]	0.0%[a]	1	1	100.0%[a]	

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.
[a] Fewer than 10 Members in the denominator. These rates should be reviewed with caution.
[b1] Both denominator and numerator increased this year. For Assisted Living Services/Programs, the denominator increased from 13 to 24 and numerator increased from 11 to 14; for Home Delivered Meals, the denominator increased from 17 to 32 and numerator increased from 3 to 12; for PERS Monitoring, the denominator increased from 40 to 54 and numerator increased from 30 to 31. However, there is no statistically significant difference between 2023 and 2024 rates.
[b2] Both denominator and numerator decreased this year. For Medical Day Services, the denominator decreased from 37 to 26 and numerator decreased from 23 to 8; for PCA, the denominator decreased from 40 to 30 and numerator decreased from 24 to 10. However, there is statistically significant difference between the current year and the previous year.
[b3] Both denominator and numerator increased this year: for Assisted Living Services/Programs, the denominator increased from 2 to 13 and the numerator increased from 2 to 5. However, there is no significant statistical difference between the current year and the previous year.
[b4] Both denominator and numerator decreased this year: for Home Delivered Meals, the denominator decreased from 24 to 17 and the numerator decreased from 5 to 2. However, there is no significant statistical difference between the current year and the previous year.
[b5] Both denominator and numerator decreased this year: for PCA, the denominator decreased from 51 to 47 and the numerator decreased from 24 to 11. However, there is significant statistical difference between the current year and the previous year.
[b6] Both denominator and numerator increased this year: For Assisted Living Services/Programs, the denominator increased from 14 to 29 and the numerator increased from 13 to 28; for PCA, the denominator increased from 42 to 43 and the numerator increased from 16 to 23. However, there is no statistically significant difference between 2024 and 2023.

[b7] Both denominator and numerator decreased this year: For PERS Monitoring, the denominator decreased from 63 to 51 and the numerator decreased from 54 to 39. However, there is no statistically significant difference between 2024 and 2023.
[b8] Both denominator and numerator increased this year: for Assisted Living Services/Programs, the denominator increased from 3 to 19 and the numerator increased from 0 to 16; for Home Delivered Meals, the denominator increased from 14 to 29 and the numerator increased from 0 to 9; for Medical Day Services, the denominator increased from 10 to 14 and the numerator increased from 0 to 5; for PCA, the denominator increased from 46 to 51 and the numerator increased from 2 to 20. There is a statistically significant difference between the 2024 and 2023 rates.
[b9] Both denominator and numerator increased this year: for PERS Monitoring, the denominator increased from 26 to 33 and the numerator increased from 23 to 28. However, there is no statistically significant difference between the 2024 and 2023 rates.
[b10] Both denominator and numerator increased this year: for Assisted Living Services/Programs, the denominator increased from 2 to 14 and the numerator increased from 1 to 12. There is no statistically significant difference between the 2024 and 2023 rates.
[b11] Both denominator and numerator decreased this year: for Medical Day Services, the denominator decreased from 32 to 21 and the numerator decreased from 9 to 6; for PERS Monitoring, the denominator decreased from 62 to 50 and the numerator decreased from 20 to 14. There is no statistically significant difference between the 2024 and 2023 rates.

Table 30: Proportion of MLTSS Services At or Above the 95% Average Service Delivery Threshold, All Plans

Services Evaluated	2024 D	2024 N	2024 %	2023 D	2023 N	2023 %	Change from 2023
Assisted Living Services/Programs	99	75	75.8%	34	27	79.4%	-3.6%
Chore Services							
Community Residential Services	4	1	25.0%[a]	7	0	0.0%[a]	25.0%
Home Delivered Meals	139	45	32.4%	123	22	17.9%	14.5%
Medical Day Services	134	43	32.1%	148	58	39.2%	-7.1%
Medication Dispensing Device Monthly Monitoring	8	3	37.5%[a]	9	6	66.7%[a]	-29.2%
PCA/Home-Based Supportive Care	218	83	38.1%	228	84	36.8%	1.3%
PERS Monitoring	249	155	62.2%	253	170	67.2%	-5.0%
Private Duty Nursing	9	3	33.3%[a]	5	0	0.0%[a]	33.3%

[a] Fewer than 10 members in the denominator. These rates should be reviewed with caution.
Gray shading: Zero denominator for the Service; numerator and rate are not applicable.
MLTSS: Managed Long-Term Services and Supports; D: Denominator; N: Numerator; PCA: Personal Care Assistant; PERS: Personal Emergency Response System.

Table 31 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 34.6%, an increase of 3.5 percentage points from the rate of 31.1% for the prior year. It is observed that three MCOs demonstrated a better performance this year: HNJH's compliance rate increased by 13.1 pp from 37.4% in the prior year to 50.5%, UHCCPs compliance rate increased by 30.5 pp from 10.6% in the prior year to 41.1%, and WPNJs compliance rate increased by 13.1 pp from 18.4% in the prior year to 31.5%. Two MCOs demonstrated lower performance this year: ABHNJ's compliance rate decreased by 22.7 pp from 53.3% in the prior year to 30.6% in the current year and FC/WCHP's compliance rate decreased by 9.1 pp from 30.4% in the prior year to 21.3% in the current year (**Table 31)** HNJH achieved the highest compliance rate, with a rate of 50.5%.

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 score at or above 95% for each service documented in the POC for each member. Of the 520 total members in the denominator, 180 (34.6%) received, on average, 95% of the planned service amount for all services documented in the POC (**Table 31**).

Table 31: Compliance Rates

MCO	2024 D	2024 N	2024 Compliance Rate	2023 D	2023 N	2023 Compliance Rate	Change in Rate from Prior Year
ABHNJ	108	33	30.6%	92	49	53.3%	-22.7%
FC/WCHP	108	23	21.3%	102	31	30.4%	-9.1%
HNJH	101	51	50.5%	99	37	37.4%	13.1%
UHCCP	95	39	41.1%	66	7	10.6%	30.5%
WPNJ	108	34	31.5%	98	18	18.4%	13.1%
Total	520	180	34.6%	457	142	31.1%	3.5%

MCO: Managed Care Organization; D: Denominator; N: Numerator.

WYE 2025 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 services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: 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.

IPRO was tasked with assessing the feasibility of producing PM #13 using administrative data rather than Care Management record review. The result of this assessment was the determination that use of administrative data, based on comparison of authorization data and claims data to calculate PM #13, was not feasible. PM #13 is calculated using Plans of Care and claims data. Additionally, IPRO has included Compliance Score Ranges for the delivery of MLTSS Services.

For the measurement period (July 01, 2024–June 30, 2025), random samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The audit is in progress and final results will be reflected in next year's ATR.

Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. To meet these federal requirements, DMAHS has contracted with IPRO, an EQRO, to conduct a review of compliance with Medicaid and CHIP managed care regulations. The Annual Assessment of MCO operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of *Title 42 CFR § 438.360(a)(1)*. The Annual Assessment of MCO operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. All five MCOs participated in a 2025 compliance review: ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ.

In 2025, 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: two consecutive years of partial audits followed by one 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 2025, full reviews were conducted for ABHNJ, HNJH, UHCCP, and WPNJ. FC/WCHP participated in a partial review. The reviews evaluated each health plan on 15 standards based on contractual requirements.

The assessment type applied to ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ in 2025 is outlined in **Table 32.**

Table 32: 2025 Annual Assessment Type by MCO

MCO	Assessment Type
ABHNJ	Full
FC/WCHP	Partial
HNJH	Full
UHCCP	Full
WPNJ	Full

MCO: Managed Care Organization.

Technical Methods of Data Collection and Analysis

IPRO reviewed each MCO in accordance with the 2023 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 MCO as evidence of compliance with the 15 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and audit activities. To assist in submission of appropriate documentation, IPRO developed the *Annual Assessment of MCO Operations Review Submission Guide*. Beginning in 2025, there were changes in the Access Standard Category which included Provider Network submissions and waivers that may have attributed to the increase in score for the Access category.

This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by review standard (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, 2024–June 30, 2025.

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

Description of Data Obtained

IPRO reviewers conducted offsite file reviews for all MCOs. Select files were examined for evidence of implementation of contractual requirements related to credentialing, recredentialing, and utilization management, as well as member and provider grievances and appeals. Separate file sets were selected to review Core Medicaid and MLTSS requirements. File reviews utilized the "8 and 30" file sampling methodology established by the NCQA.

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

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

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

The standard designations and assigned points used are shown in **Table 33.**

Table 33: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation

Rating	Rating Methodology	Review Type
Total Elements	Total number of elements within this standard.	Full, Partial

Rating	Rating Methodology	Review Type
Subject to Review	This element was subject to review in the current review year.	Full, Partial
Subject to Review and Met	This element was subject to review in the current review year and was met.	Full, Partial
Subject to Review and Not Met	Not all of the required parts within the element were met.	Full, Partial
Subject to Review and N/A	This element is not applicable (N/A) and will not be considered as part of the score.	Full, Partial
Total Met	In a full review, this element was met among the elements subject to review in the current review year. In a partial review, this element was subject to review and met or deemed met.	Full, Partial

Conclusions and Comparative Findings

As part of the Annual Assessment of MCO operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI standards. CMS requires each MCO's compliance with these 14 standards to be evaluated. **Table 34** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI standards.

Of the 232 elements reviewed during the 2025 Core Medicaid and MLTSS Annual Assessments, 94 elements crosswalk to the 14 CMS QAPI standards. **Table 34** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI standards identified by CMS.

Table 34: Subpart D and QAPI Standards – Scores by MCO

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
Disenrollment	438.56	5.10.2.A 5.10.2.A.1 5.10.2.A.2 5.10.1.A 5.10.3.A 5.10.3.A.1 5.10.3.A.2 5.10.3.A.3 5.10.3.A.4 5.10.3.A.5 5.10.3.A.6 5.10.2.D	MD1-MD8, MD10	9	100%	100%	100%	78%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Enrollee rights	438.100	B.4.14.X.A B.4.14.X.C B.4.14.X.F B.4.14.X.J	ER1, ER3 -ER4	3	100%	100%	100%	67%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
Emergency and post-stabilization	438.114	4.2.1.B 4.2.1.H.4	EPS1	1	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Availability of services	438.206	4.6.3 4.1.1.L. 4.8.7.G 4.1.1.L.3 4.8.3 4.8.3.D 4.11 4.11.A 4.7.2.A.3 4.7.2.A.10 5.12 B.4.14.X.I B.4.14.XI B.4.14.IX.E B.4.14.IX.F 4.9.3.A	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	92%	83%	92%	75%	92%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
		4.9.3.B 4.9.3.C									
Assurances of adequate capacity and services	438.207	4.5.1.F 4.8.1.A 4.8.1.E 4.8.1.J 4.2.2.A 4.2.3.D 7.8.E	A4	1	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Coordination and continuity of care	438.208	4.6.2.J 4.6.5.B.2 4.6.5.B.3 4.6.5.B.4 4.6.5.B.5 4.6.5.B.6 4.6.2.O, 4.6.5.M 9.5.1.F 9.5.1.G 9.2.2 9.5.5. K 9.4.1.A.4 9.5.1. E	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	11	64%	73%	64%	82%	82%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	CFR Citation	State Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	FC/ WCHP	HNJH	UHCCP	WPNJ	Full Review Years	Partial Review Years
											FC/WCHP – 2024-2025
Coverage and authorization of services	438.210	4.6.4.A B.4.14.XIII 4.6.4.B.4 4.6.4.B.7 4.6.4.B.8 5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.5	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	7	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Provider selection	438.214	4.6.1.C.5 B.4.14.IX.A 4.8.2.A	CR2, CR3, CM27	3	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024

Subpart D and QAPI Standards[1]	CFR Citation	State Citation	AA Review Elements	# of Elements Reviewed	2024-2025 MCO Scores					MCO Compliance Review by Year	
					ABHNJ	FC/ WCHP	HNJH	UHCCP	WPNJ	Full Review Years	Partial Review Years
											FC/WCHP – 2024-2025
Confidentiality	438.224	B.4.14.X.K	PT9	1	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ - 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Grievance and appeal systems	438.228	5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.4 4.6.4.B.5 4.6.4.B.7 4.6.4.B.8 4.6.2.E	UM16a – UM16d, UM16f-UM16i, QM5	9	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ -– 2023-2024

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
											FC/WCHP – 2024-2025
Subcontractual relationships and delegation	438.230	4.9.6.A - I, B.4.14.VIII.B B.4.14.VIII.C B.4.14.VIII.D B.4.14.VIII.E	AO5, AO8– AO11	5	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Practice guidelines	438.236	B.4.14.II.A-G 4.6.2.A 4.6.2.C 4.6.2.R.1.c 4.6.2.R.2.a.i 4.6.2.R.2.c.iv 4.6.2.R.2.d.iv	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
											FC/WCHP – 2024-2025
Health information systems	438.242	3.1.2.A.1 3.1.2.A.2 3.1.2.A.3 3.1.2.A.4 3.1.2.A.5 3.1.2.A.6 3.1.3.A 3.1.3.B 3.7.1.A 3.7.1.A.3 3.7.1.A.7 3.8 3.8.1.D 3.1.2.F 3.1.2.G 3.1.2.I 3.1.2.J 3.1.2.K	IS1–IS17	17	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP, WPNJ – 2023-2024 FC/WCHP – 2024-2025
Quality assessment and performance improvement program	438.330	4.6.1.A 4.6.2 B.4.14.II B.4.14.VI B.4.14.VII.A B.4.14.VII.E B.4.14.XV.A B.4.14.XVI	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%	100%	FC/WCHP – 2023-2024 ABHNJ, HNJH, UHCCP, WPNJ – 2024-2025	ABHNJ, HNJH, FC/WCHP, UHCCP, WPNJ – 2022-2023 ABHNJ, HNJH, UHCCP,

					2024-2025 MCO Scores					MCO Compliance Review by Year	
Subpart D and QAPI Standards[1]	**CFR Citation**	**State Citation**	**AA Review Elements**	**# of Elements Reviewed**	**ABHNJ**	**FC/ WCHP**	**HNJH**	**UHCCP**	**WPNJ**	**Full Review Years**	**Partial Review Years**
											WPNJ – 2023-2024 FC/WCHP – 2024-2025
Total elements reviewed				**94**							
Compliance percentage					**95%**	**95%**	**95%**	**91%**	**97%**		

[1] DMAHS requires specific elements to be reviewed annually.
EQRO: external quality review organization; CFR: Code of Federal Regulations.

All five MCOs participated in the 2025 compliance review. A total of 232 elements were reviewed by each MCO for a total of 1,160 elements reviewed overall (data not shown). All five NJ MCOs showed strong performance in the CMS Subpart D and QAPI standards. All five MCOs received 100% compliance for 10 or more of the 14 standard domains. All five MCOs were non-compliant in Availability of Services and Coordination and Continuity of Care (**Table 34**).

Table 35 displays a comparison of the overall compliance score for each of the five MCOs from 2024 to 2025. For the review period July 1, 2024–June 30, 2025, ABHNJ, FC/WCHP HNJH, UHCCP, and WPNJ scored above NJ's minimum threshold of 85%. The 2025 compliance scores from the Annual Assessment ranged from 97% to 99% (**Table 35)**. ABHNJ's compliance score increased from 98% to 99%; FC/WCHP's compliance score Increased from 95% to 98%; HNJH's compliance score remained consistent at 99%; UHCCP's compliance score decreased from 98% to 97%; WPNJ's compliance score increased from 97% to 99% (**Table 35**).

Table 35: Comparison of 2024 and 2025 Compliance Scores by MCO

MCO	2024 Compliance %	2025 Compliance %	Percentage Point Change from 2024 to 2025
ABHNJ	98%	99%	+1%
FC/WCHP	95%	98%	+3%
HNJH	99%	99%	0%
UHCCP	98%	97%	-1%
WPNJ	97%	99%	+2%

MCO: Managed Care Organization.

In 2025, the average compliance score for two standards (Access and Member Disenrollment) showed increases ranging from 2 to 17 percentage points (**Table 36**). In 2025, nine standards (Emergency and Post-Stabilization Services, QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Utilization Management, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for twelve standards (Emergency and Post-Stabilization Services, QAPI, Quality Management, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Credentialing and Recredentialing, Utilization Management, Administration and Operations, and Management Information Systems) remained the same from 2024 to 2025 (**Table 36**). One standard (Enrollee Rights and Responsibilities) decreased 2 percentage points from 2024 to 2025. Access had the lowest average compliance score at 82% (**Table 36**).

Table 36: 2024 and 2025 Compliance Scores by Review Category

Review Category[1]	MCO Average 2024[2]	MCO Average 2025[2]	Percentage Point Change from 2024 to 2025
Care Management and Continuity of Care – Core Medicaid[1]	77%	83%	6%
Care Management and Continuity of Care – MLTSS[1]	100%	100%	0%
Access	65%	82%	17%
Emergency and Post-Stabilization Services	100%	100%	0%
Quality Assessment and Performance Improvement	100%	100%	0%
Quality Management	97%	97%	0%
Efforts to Reduce Healthcare Disparities	100%	100%	0%
Committee Structure	100%	100%	0%
Programs for the Elderly and Disabled	100%	100%	0%

Review Category[1]	MCO Average 2024[2]	MCO Average 2025[2]	Percentage Point Change from 2024 to 2025
Provider Training and Performance	100%	100%	0%
Satisfaction	96%	96%	0%
Enrollee Rights and Responsibilities	100%	98%	-2%
Member Disenrollment	97%	99%	2%
Credentialing and Recredentialing	98%	98%	0%
Utilization Management	100%	100%	0%
Administration and Operations	100%	100%	0%
Management Information Systems	100%	100%	0%
Total[3]	**97%**	**98%**	**1%**

[1] In 2024 and 2025, the Care Management scores were not included in the overall compliance score.
[2] Managed Care Organization (MCO) average is the average of the compliance scores for the five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ).
[3] Total is the average compliance scores listed in **Table 36**.
MLTSS: Managed Long-Term Services and Supports; N/A: not applicable.

Individual MCO 2025 Annual Assessment scores by element can be found in **Appendix A: January 2025–December 2025 NJ MCO-Specific Review Findings**.

Figure 2 depicts compliance scores in 2023–2025. Compliance scores for the five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) have remained at or above 93% for all 3 years.

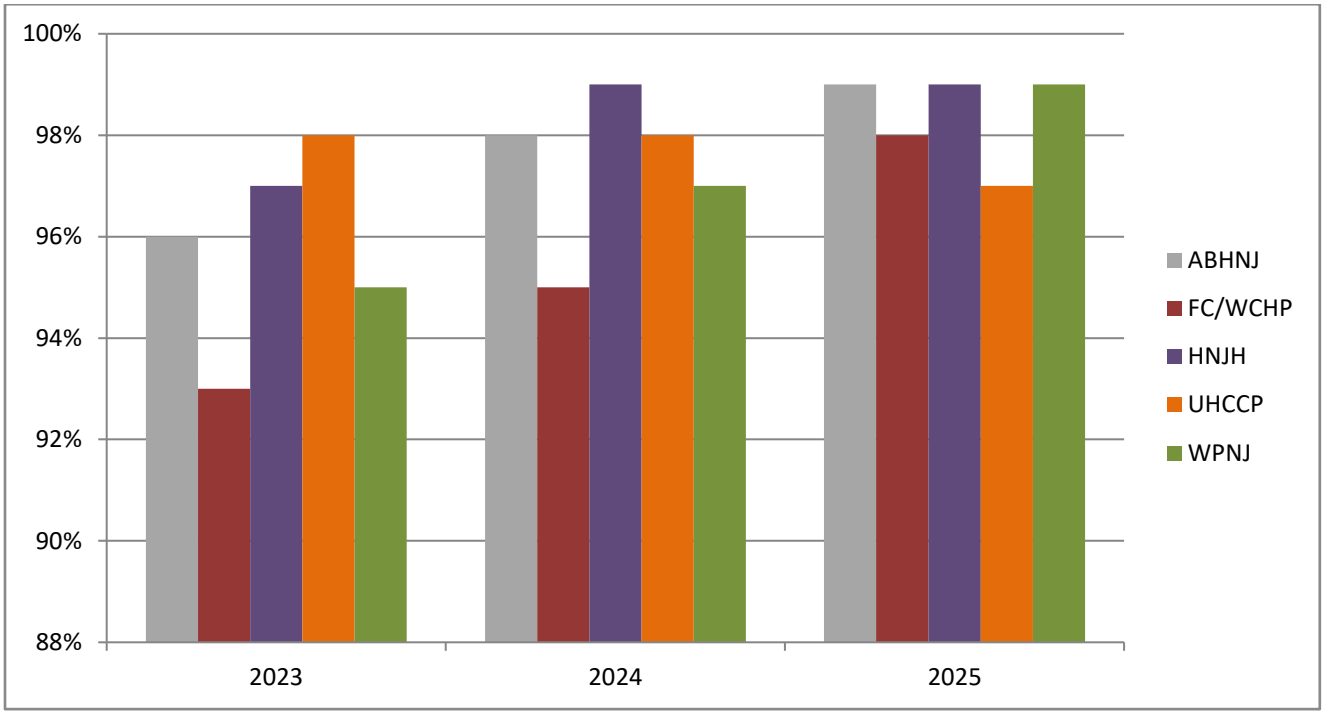

Figure 2: MCO Compliance Scores by Year (2023–2025) Compliance scores for Aetna Better Health of New Jersey (ABHNJ, gray); Fidelis Care (FC/WCHP, red); Horizon NJ Health (HNJH, purple), UnitedHealthcare Community Plan (UHCCP, orange); and Wellpoint New Jersey, Inc. (WPNJ, green) are shown for 2023–2025.

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 2025 Annual Assessment of MCO operations are:

- The QAPI program delineates an identifiable committee structure responsible for performing QI activities and demonstrates ongoing initiatives.
- All five MCOs continue to perform well with regard to Emergency and Post-Stabilization Services, QAPI, Quality Management, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, Utilization Management, Administration and Operations, and Management Information Systems.

Recommendations and 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 recommends for improvement:

- continue efforts in provider recruitment and improving access to hospitals, dental services, and primary care providers (PCPs) in all counties, including access to and coverage of out-of-network services as necessary;
- continue to expand the MLTSS network to include at least two providers in every county;
- continue to focus on improving appointment availability for adult PCPs, specialists, and behavioral health (BH) 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 the implementation of the PIPs; and
- develop a comprehensive approach to ensure applicable PM documentation is submitted correctly and timely.

Protocol 4: Validation of Network Adequacy

Objectives

Title 42 CFR § 438.356 State contract options for external quality review and *Title 42 CFR § 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with CMS's *External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy*. In 2025, IPRO's evaluation included the NJ FamilyCare networks of ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' methods and scopes of reporting practice-site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed NJ Medicaid MCO provider look-up systems between August 2025 and September 2025 to prepare the MCO samples. **Table 37** displays the website addresses of the MCO provider look-up systems, the date range the look-up systems were accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 37: Survey Administration Summary

MCO	Website Address of Provider Directory/Date
ABHNJ	https://www.aetnabetterhealth.com/newjersey/find-provider
FC/WCHP	https://findaprovider.fideliscarenj.com/location
HNJH	https://www.horizonnjhealth.com/findadoctor
UHCCP	https://member.uhc.com/communityplan
WPNJ	https://www.wellpoint.com/nj/medicaid/search-providers
Website access dates	8/2/2025–8/22/2025
Survey date range	8/11/2025–9/16/2025

MCO: Managed Care Organization.

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed Long-Term Services and Supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with one of the five Medicaid MCOs.

A random sample totaling 1,750 providers was prepared for NJ DMAHS.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed the MCOs' provider look-up systems to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider

directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in **Table 38**, the overall provider directory access rate was 48.0%**,** with the highest compliance rate observed among pediatric specialists (**Table 39**).

Individual *MCO 2025 Provider Directory Validation Survey* reports and scores by element can be found in **Appendix G.**

Table 38: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
1,750	840	48.0%

[1] Total number of providers in the sample (no exclusions).
[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 39: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	1,000	447	44.7%
Pediatric Specialists	250	146	58.4%
Dental	250	124	49.6%
Managed Long-Term Services and Supports	250	123	49.2%
Total	1,750	840	48.0%

[1] Providers who positively confirmed participation with the Managed Care Organization (MCO) and open panel status for the listed specialty.

Conclusions and Comparative Findings

The overall response rate for the provider directory validation survey was 48.0% (**Table 39**). Pediatric specialists responded at a higher rate than any other provider type, at 58.4%. Response rates varied by MCO as follows: 36.3% for ABHNJ, 50.6% for FC/WCHP, 41.1% for HNJH, 61.1% for UHCCP, and 50.9% for WPNJ (**Appendix G**).

Recommendations from the provider directory validation survey suggested that DMAHS follow up with the MCOs to ensure that they correct the inaccuracies that were identified. IPRO recommended the MCOs to:

- conduct routine assessments of their provider directories to ensure provider data are accurate and updated timely, as most failure reasons resulted from the provider not being at the listed site;
- conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory;
- ensure its provider network includes providers with disability accommodations, which will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment;
- regularly review the accessibility options listed under providers' profiles to ensure their accuracy; and

- implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

Encounter data validation is an ongoing process, involving the MCOs, 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 2025, 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, third-party liability (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 2025, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts and to ensure the monthly file receipt.

Protocol 6: Administration or Validation of Quality-of-Care Surveys

Objectives

Results from the HEDIS CAHPS 2025 5.1H Surveys for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following two survey vendors conducted the Adult, Child, and Children with Chronic Conditions (CCC) surveys on behalf of NJ FamilyCare MCOs: Center for the Study of Services (CSS) and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ. In addition, the certified vendor fielded the CHIP and CHIP CCC surveys, and this was the first year these were stratified by MCO. All the members surveyed required continuous enrollment from July 1, 2024, through December 31, 2024, with enrollment in that MCO at the time of the survey. Five separate reports were produced - Adult Medicaid, Child Medicaid, Child CHIP, Child CHIP CCC, Child Medicaid CCC. In addition, this is the first year that the CHIP survey was stratified by MCO.

Technical Methods of Data Collection and Analysis

The survey drew, as potential respondents, adult enrollees over the age of 18 years, and children under the age of 18 years who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2025 using a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. All five MCOs utilized the mail and telephone protocol. Additionally, all MCOs offered the option to complete the survey online. For the Child CAHPS survey, ABHNJ opted to send a third survey mailing to those who had not responded to the first two mailings.

The CHIP/CCC survey drew, as potential respondents, the parent/caretakers of child enrollees under the age of 18 who were covered by NJ FamilyCare CHIP. Respondents were surveyed in English and Spanish. The survey was administered over a 10-week period using a mixed-only protocol. The five-wave protocol consisted of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and second reminder postcard to non-respondents, and finally a phone follow-up to any remaining non-respondents.

Description of Data Obtained

For the MCO administered adult survey, a total random sample of 8,371 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,823 ABHNJ, 1,350 FC/WCHP, 1,755 HNJH, 1,890 UHCCP, and 1,553 WPNJ enrollees (data not shown). To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,408 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 17.2%, which was an increase compared to the previous year's response rate of 16.7% (data not shown).

For the MCO administered child survey, a total random sample of 21,135 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn (data not shown). This consisted of a random sample of 4,728 ABHNJ, 3,490 FC/WCHP, 5,239 HNJH, 4,188 UHCCP, and 3,490 WPNJ enrollees (data not shown). To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 4,315 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 20.8%, which was an increase compared to the previous year's response rate of 19.7% (data not shown).

For the MCO administered CCC survey, a total random sample of 21,135 cases was drawn of parent/caretakers of child enrollees from the NJ FamilyCare plans (data not shown). A first random sample was drawn from all eligible parent/caretakers of child enrollees (Sample A). Sample A consisted of a random sample of 2,888 ABHNJ enrollees, 1,650 FC/WCHP enrollees, 3,399 HNJH enrollees, 1,980 UHCCP enrollees, 1,650 WPNJ enrollees (data not shown). An additional random sample was then drawn from only parent/caretakers of child enrollees identified as having a chronic condition using a prescreen status code (Sample B). Sample B consisted of 1,840 ABHNJ enrollees, 1,840 FC/WCHP enrollees, 1,840 HNJH enrollees, 2,208 UHCCP enrollees, and 1,840 WPNJ enrollees (data not shown). To be eligible, enrollees had to be under the age of 18, and enrollees had to be continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete CCC surveys were obtained from 2,994 NJ FamilyCare child CCC enrollees, and the NJ FamilyCare child CCC response rate was 21.3% (data not shown).

For the CHIP survey, a total random sample of 13,220 parent/caretakers of CHIP child enrollees was drawn (data not shown). To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 2,493 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 19.1%, which was a decrease from last year's response rate of 20.4% (data not shown). New for this year, two additional surveys were stratified by the MCO: the Medicaid Child CHIP Survey (**Table 44**) and the Medicaid Child CHIP CCC Survey (**Table 45**).

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 40**.

Table 40: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2024 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2024 Quality Compass National Percentiles
Orange	Less than 25th percentile
Yellow	Greater than or equal to 25th and less than 50th percentile
Green	Greater than or equal to 50th and less than 75th percentile
Blue	Greater than or equal to 75th and less than 90th percentile
Purple	Great than or equal to the 90th percentile

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

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all MCOs, IPRO compared the NJ FamilyCare overall statewide weighted averages for adults and children (**Table 41-Table** 45**)** to the national Medicaid benchmarks presented in the MY 2024 Quality Compass. Measures performing at or above the 75th percentile and below the 90th percentile, and greater than or equal to the 90th percentile were considered strengths; measures performing at the 50th percentile and below the 75th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Composite results of the Adult NJ FamilyCare overall weighted responses for the five MCOs were: 94.6% for how well doctors communicate; 88.0% for customer service; 77.3% for getting needed care; and 79.0% for getting care quickly (**Table 41**).

Table 41: CAHPS MY 2024 Performance – Medicaid Adult Survey

Adult Survey – CAHPS Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	76.8%	80.6%	75.7%	78.4%	81.6%	77.3%
Getting Care Quickly	75.9%	79.6%	79.0%	78.6%	80.2%	79.0%
How Well Doctors Communicate	93.0%	91.4%	96.7%	91.1%	92.6%	94.6%
Customer Service	85.6%	86.1%	88.7%	87.5%	88.0%	88.0%
Rating of All Health Care[1]	70.4%	79.2%	78.9%	76.0%	76.9%	77.7%
Rating of Personal Doctor[1]	83.0%	84.2%	91.9%	80.7%	87.8%	88.4%
Rating of Specialist Seen Most Often[1]	76.2%	79.8%	87.0%	78.7%	83.2%	84.1%
Rating of Health Plan[1]	72.0%	76.0%	86.4%	75.8%	76.5%	81.7%

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

The composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 90.7% for how well doctors communicate; 86.8% for customer service; 83.5% for getting needed care; and 78.0% for getting care quickly (**Table 42**).

Table 42: CAHPS MY 2024 Performance – Medicaid Child Survey

Child Survey – CAHPS Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	81.2%	84.5%	83.0%	82.6%	87.1%	83.5%
Getting Care Quickly	81.0%	81.2%	76.8%	75.7%	84.8%	78.0%
How Well Doctors Communicate	91.1%	92.3%	90.2%	89.9%	93.1%	90.7%
Customer Service	87.4%	87.5%	87.1%	85.4%	87.6%	86.8%
Rating of All Health Care[1]	84.3%	86.6%	88.1%	84.2%	87.7%	87.1%
Rating of Personal Doctor[1]	86.3%	90.3%	90.6%	87.5%	90.7%	89.8%
Rating of Specialist Seen Most Often[1]	83.3%	92.9%	85.5%	85.5%	87.7%	86.0%
Rating of Health Plan[1]	80.5%	83.3%	89.5%	83.7%	84.8%	87.2%

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

The composite results of the Child CCC NJ FamilyCare overall weighted responses for the five MCOs were: 91.4% for how well doctors communicate; 87.0% for customer service; 84.1% for getting needed care; and 78.8% for getting care quickly (**Table 43**).

Table 43: CAHPS MY 2024 Performance – Medicaid Child CCC Survey

Child CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	81.4%	84.4%	84.4%	81.8%	86.4%	84.1%
Getting Care Quickly	82.3%	84.8%	77.5%	76.3%	84.8%	78.8%

Child CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
How Well Doctors Communicate	91.5%	92.3%	91.6%	89.6%	92.8%	91.4%
Customer Service	87.7%	89.5%	86.9%	86.2%	88.0%	87.0%
Access to Specialized Services	60.4%	65.5%	67.6%	63.1%	64.2%	65.8%
Family Centered Care[2]	86.9%	87.4%	86.8%	83.6%	88.3%	86.4%
Coordination of Care	65.1%	67.0%	70.0%	64.6%	60.7%	67.2%
Rating of All Health Care[1]	83.8%	86.2%	88.2%	84.8%	87.1%	87.2%
Rating of Personal Doctor[1]	86.5%	90.2%	90.2%	88.0%	90.4%	89.6%
Rating of Specialist Seen Most Often[1]	84.7%	92.6%	86.8%	85.8%	87.9%	86.9%
Rating Of Health Plan[1]	81.7%	86.1%	87.5%	83.9%	86.2%	86.3%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.
[2] No benchmarks available in Quality Compass.
CAHPS: Consumer Assessment of Healthcare Providers and Systems.

The composite results of the Child CHIP NJ FamilyCare overall weighted responses for the five MCOs were: 93.8% for how well doctors communicate; 83.0% for customer service; 84.1% for getting needed care; and 76.7% for getting care quickly (**Table 44**).

Table 44: CAHPS MY 2024 Performance – Medicaid Child CHIP Survey

Child CHIP Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	80.7%	76.0%	85.7%	81.8%	83.8%	84.1%
Getting Care Quickly	76.8%	73.0%	75.9%	76.0%	82.2%	76.7%
How Well Doctors Communicate	94.3%	94.9%	93.2%	94.1%	94.9%	93.8%
Customer Service	83.9%	91.2%	83.3%	80.3%	83.1%	83.0%
Rating of All Health Care[1]	83.5%	90.0%	87.7%	87.1%	88.4%	87.5%
Rating of Personal Doctor[1]	88.8%	95.9%	89.9%	90.1%	92.0%	90.4%
Rating of Specialist Seen Most Often[1]	83.6%	81.3%	90.6%	84.4%	80.0%	87.4%
Rating Of Health Plan[1]	75.1%	81.9%	83.7%	81.6%	79.6%	82.1%

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

The composite results of the Child CHIP CCC NJ FamilyCare overall weighted responses for the five MCOs were: 93.0% for how well doctors communicate; 82.3% for customer service; 79.4% for getting needed care; and 77.3% for getting care quickly (**Table 45**).

Table 45: CAHPS MY 2024 Performance – Medicaid Child CHIP CCC Survey

Child CHIP CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	76.5%	67.2%	81.3%	82.1%	72.4%	79.4%

Child CHIP CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Care Quickly	79.9%	68.8%	75.4%	78.8%	86.2%	77.3%
How Well Doctors Communicate	94.1%	96.7%	93.0%	91.9%	92.7%	93.0%
Customer Service	78.9%	90.0%	83.8%	79.0%	81.8%	82.3%
Access to Specialized Services	64.8%	75.0%	64.8%	72.7%	52.6%	64.6%
Family Centered Care[2]	85.2%	93.3%	86.2%	87.8%	87.8%	86.9%
Coordination of Care	56.1%	43.3%	62.3%	67.9%	43.6%	59.4%
Rating of All Health Care[1]	77.8%	88.9%	85.7%	84.6%	78.9%	84.1%
Rating of Personal Doctor[1]	80.0%	96.2%	87.2%	83.3%	85.7%	86.1%
Rating of Specialist Seen Most Often[1]	83.9%	85.7%	89.4%	82.6%	76.0%	86.0%
Rating Of Health Plan[1]	62.7%	69.0%	79.9%	76.0%	70.3%	76.4%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.
[2] No benchmarks available in Quality Compass.
CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Weighted statewide average rates ranked at or above the NCQA national 50th percentile for five of the eight adult measures (**Table 41**). Opportunities for improvement are evident for the three adult measures (Getting Needed Care, Getting Care Quickly, and Customer Service). Weighted statewide average rates ranked at or above the NCQA national 50th percentile for one of the eight child measures (**Table 42**). Opportunities for improvement are evident for seven of the eight child measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often). Weighted statewide average rates ranked at or above the NCQA national 50th percentile for three of the eleven child CCC measures (**Table 43**). Opportunities for improvement are evident for seven CCC measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Access to Specialized Services, Coordination of Care, and Rating of Specialist Seen Most Often). There was no benchmark available for Family Centered Care. Weighted statewide average rates ranked at or above the NCQA national 50th percentile for three of the eight child CHIP measures (**Table 44**). Opportunities for improvement are evident for five of the eight child CHIP measures (Getting Care Quickly, How Well Doctors Communicate, Customer Service, Rating of Personal Doctor, and Rating of Health Plan). Weighted statewide average rates ranked below the NCQA national 50th percentile for all eleven child CHIP CCC measures (**Table 45**). Opportunities for improvement are evident for all of the child CHIP CCC measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Access to Specialized Services, Coordination of Care, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Rating of Health Plan). There was no benchmark available for Family Centered Care.

For the adult survey measures, all eight measures were below the 50th percentile for ABHNJ and UHCCP (**Table 41**). FC/WCHP had one measure between 75th and 90th percentile. HNJH had one measure between the 50th and 75th percentile, one measure between the 75th and 90th percentile, and three measures greater than the 90th percentile. WPNJ had one measure between the 50th and 75th percentile and one measure between 75th and 90th percentile (**Table 41**).

For the child survey measures, all eight measures were below the 50th percentile for ABHNJ and UHCCP (**Table 42**). FC/WCHP had one measure between the 50th and 75th percentile and one measure greater than the 90th percentile. HNJH had one measure between the 50th and 75th percentile and one measure between the 75th and 90th percentile. WPNJ had three measures between the 50th and 75th percentiles (**Table 42**).

For the child CCC survey measures, all ten measures were below the 50th percentile for ABHNJ (**Table 43**; Family Centered Care does not have a benchmark available). FC/WCHP had three measures between the 50th and 75th percentiles, one measure between the 75th and 90th percentile, and one measure greater than the 90th percentile. HNJH had one measure between the 50th and 75th percentile and two measures between the 75th and 90th percentiles. UHCCP had one measure between the 50th and 75th percentile. WPNJ had five measures between the 50th and 75th percentiles and one measure between the 75th and 90th percentile (**Table 43**).

For the child CHIP survey measures, ABHNJ had one measure between the 50th and 75th percentile (**Table 44**). FC/WCHP had one measure between 50th and 75th percentile, two measures between the 75th and 90th percentile, and one measure above the 90th percentile. HNJH had two measures between the 50th and 75th percentiles and one measure between the 75th and 90th percentile. UHCCP had one measure between 50th and 75th percentile. WPNJ had three measures between the 50th and 75th percentiles (**Table 44**).

For the child CHIP CCC survey measures, all ten measures were below the 25th percentile for WPNJ (**Table 45**; Family Centered Care does not have a benchmark available). FC/WCHP had two measures between the 50th and 75th percentiles, one measure between the 75th and 90th percentile, and two measures greater than the 90th percentile. HNJH had one measure between the 50th and 75th percentile and one measure between the 75th and 90th percentile. All ten measures for ABHNJ and UHCCP were below the 50th percentile (**Table 45**).

Protocol 9: Conducting Focus Studies of Health Care Quality

2025 MCO Verification of Enrollment in Care Management Focus Study

IPRO was requested to conduct a focus study on MCO verification of enrollment in Care Management (CM). The purpose of this focus study was to evaluate the MCO's CM enrollment process(es) for compliance with the New Jersey FamilyCare Contract and the *NJ Care Management Workbook* requirements for the DDD and DCP&P populations.

The review period for this study was July 1, 2023, through December 31, 2024, and included an offsite desk audit to review selected files, and a system review conducted virtually via Microsoft Teams.

Sampling

IPRO selected a random sample of 50 DDD enrollee files and 50 DCP&P enrollee files (including an oversample for each population) for review.

System Review

In addition to the file review, the MCOs were required to submit their CM enrollment workflow process that incorporated the following specifications:

- documentation of MCO administrative and clinical activities from the MCO receipt of eligibility file (the 834 file) through assignment/enrollment in CM;
- for each step action process, document staff name, staff title, and the department responsible for the task and include timeframes for each task; and
- any optional flowcharts, detailed narratives, or enumerated items to outline the MCO enrollment in CM workflow process.

The findings for the *2025 MCO Verification of Enrollment in Care Management Focus Study* are listed in **Table 46-Table** 48**.**

Table 46: Focus Study-Verification of Enrollment in Care Management-DDD Population

Compliance Evaluation	MCO	DDD Population			
		Numerator	Denominator	Rate	Met/Not Met
The newly eligible Enrollee was enrolled in Care Management during the review period.	ABHNJ	28	50	56.0%	Not Met
	FC/WCHP	48	50	96.0%	Not Met
	HNJH	48	50	96.0%	Not Met
	UHCCP	50	50	100.0%	Met
	WPNJ	50	50	100.0%	Met

Table 47: Focus Study-Verification of Enrollment in Care Management-DCP&P Population

Compliance Evaluation	MCO	DCP&P Population			
		Numerator	Denominator	Rate	Met/Not Met
The newly eligible Enrollee was enrolled in Care Management during the review period.	ABHNJ	42	50	84.0%	Not Met
	FC/WCHP	49	49	100.0%	Met
	HNJH	50	50	100.0%	Met
	UHCCP	50	50	100.0%	Met
	WPNJ	49	50	98.0%	Not Met

Table 48: Focus Study-System Compliance Evaluation

System Compliance Evaluation	MCO	DDD Population	DCP&P Population
		Met/Not Met	Met/Not Met
Identification of Enrollees Who Need Care Management: The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. Reference: 4.6.5.B.1	ABHNJ	Met	Met
	FC/WCHP	Met	Met
	HNJH	Met	Met
	UHCCP	Met	Met
	WPNJ	Met	Met
The MCOs are required to develop internal integrated electronic information systems with seamless interoperability in order to provide Care Managers with access to all essential data related to the Enrollee. Reference: Care Management Workbook	ABHNJ	Met	Met
	FC/WCHP	Met	Met
	HNJH	Met	Met
	UHCCP	Met	Met
	WPNJ	Met	Met

Care Management Audits

2025 Core Medicaid Care Management Audit and Annual Assessment

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

MCO Care Management Chart Audit

Assessment Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Summary of Core Medicaid Care Management Audit Performance

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 49**, were calculated using the sum of the numerators

divided by the sum of the denominators for determinations included in each category for each population. Compliance threshold in an audit category is 85% or above.

Table 49: Core Medicaid Care Management Summary of Performance

Determination by Category	ABHNJ MY 2024	FC/WCHP MY 2024	HNJH MY 2024	UHCCP MY 2024	WPNJ MY 2024
GP	n = 100	n = 100	n = 100	n = 100	n = 72
Identification[1]	67.6%	72.4%	77.5%	95.7%	98.1%
Outreach[2,3]	86.0%	50.0%	94.4%	100.0%	72.0%
Preventive Services[3]	84.3%	100.0%	100.0%	100.0%	95.1%
Continuity of Care[3]	96.9%	98.0%	98.6%	99.7%	94.2%
Coordination of Services[3]	93.3%	99.4%	99.5%	99.7%	99.1%
DDD	n = 100	n = 100	n = 100	n = 100	n = 100
Outreach[2,3]	100.0%	100.0%	100.0%	100.0%	100.0%
Preventive Services[3]	27.8%	92.2%	66.2%	98.4%	83.5%
Continuity of Care[3]	61.7%	96.7%	87.9%	99.1%	90.5%
Coordination of Services[3]	59.6%	95.1%	73.0%	99.7%	99.4%
DCP&P	n = 74	n = 20	n = 84	n = 100	n = 30
Outreach[2,3]	91.7%	50.0%	100.0%	N/A	N/A
Preventive Services[3]	58.5%	100.0%	50.0%	93.3%	100.0%
Continuity of Care[3]	86.3%	97.8%	95.1%	99.8%	99.0%
Coordination of Services[3]	96.5%	93.5%	87.7%	100.0%	93.3%

[1] The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2] The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3] Aggregate scores represent a combination of new and existing population specific rates.
N/A: not applicable, no DCP&P Enrollees met criteria for this measure as all comprehensive needs assessments (CNAs) were completed timely; MY: Measurement Year.

ABHNJ's 2025 audit results ranged from 27.8% to 100% across all populations for the five audit categories, FC/WCHP's results ranged from 50.0% to 100%, HNJH's results ranged from 50.0% to 100%, UHCCP's results ranged from 93.3% to 100%, and WPNJ's 2025 audit results ranged from 72.0% to 100% across all populations for the five audit categories (**Table 49**).

Core Medicaid Care Management Annual Assessment

Assessment Methodology

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

General Population who would benefit from Care Management (CM) services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate State Divisions for individuals with special needs. To assist in submission of appropriate documentation, IPRO developed the *Core Medicaid Care Management Document Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The 2025 CM assessment covered the period from January 1, 2024, to December 31, 2024. The documentation review occurred offsite at IPRO beginning on April 7, 2025.

There were 30 elements in this review based on contractual provisions, which are subject to review annually. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Overall compliance scores for the five MCOs ranged from 73% to 90% (**Table 50**). Where appropriate, the assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for CY 2024 for three populations, namely the enrollees in the General, DDD and DCP&P populations. **Table 51** presents an overview of the results by MCO.

Table 50: Summary of Findings for 2025 Core Medicaid Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	30	22	8	73%
FC/WCHP	30	26	4	87%
HNJH	30	24	6	80%
UHCCP	30	26	4	87%
WPNJ	30	27	3	90%

MCO: Managed Care Organization.

Table 51 presents the findings for the Core Medicaid Care Management and Continuity of Care elements reviewed in 2025. Complete findings and IPRO's recommendations for each MCO can be located in **Appendices B–F.**

Table 51: Findings for 2025 Core Medicaid Care Management and Continuity of Care

Element	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM1	X	X	X	X	X
CM2	-	-	X	-	X
CM3	X	X	X	X	X
CM4	X	X	X	X	X
CM5	X	X	X	X	X
CM6	-	-	-	-	X
CM7	-	-	-	X	-
CM8	-	X	-	X	X
CM9	X	X	X	X	X
CM10	X	X	X	X	X
CM11	X	X	-	X	X

Element	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM12	X	X	X	X	X
CM13	X	X	X	X	X
CM14	-	-	-	-	-
CM15	-	X	X	X	X
CM16	X	X	X	X	X
CM17	X	X	X	-	X
CM18a	X	X	X	X	X
CM18c	X	X	X	X	X
CM18d	X	X	X	X	X
CM19	-	X	-	X	-
CM20	X	X	X	X	X
CM21	X	X	X	X	X
CM22	X	X	X	X	X
CM23	X	X	X	X	X
CM24	X	X	X	X	X
CM25	X	X	X	X	X
CM26	X	X	X	X	X
CM27	X	X	X	X	X
CM37[1]	-	X	X	X	X
Total elements = 30	**22**	**26**	**24**	**26**	**27**
Compliance percentage	**73%**	**87%**	**80%**	**87%**	**90%**

[1] This documentation element is reviewed annually as all elements are subject to review.
Letter x (X) indicates "Met", and hyphen (-) indicates "Not Met".

FC/WCHP, UHCCP, and WPNJ met the compliance threshold of 85% or above (**Table 51**). All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in the **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section, and also in **Appendices B–F**.

2025 MLTSS Nursing Facility Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), were consistent with professionally recognized standards of care. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in a NF/SCNF for at least six consecutive months within the review period from July 1, 2024, through June 30, 2025.

The 2025 MLTSS NF/SCNF audit was in progress during the reporting period; final audit rates will be reflected in the subsequent ATR.

2025 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. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

Annually, DMAHS evaluates the MCO performance against these requirements through its EQRO contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Contract (Article 9). A representative sample of files were selected for each MCO for review. (**Table 52)**. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Table 52: Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.

Subpopulations	Criteria
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS: Managed Long-Term Services and Supports; HCBS: Home and Community Based Services; MCO: Managed Care Organization.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (*Plan of Care for MLTSS Members amended based on change of Member condition).* IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented and applying the sampling methodology described in **Table 53.**

Table 53: MLTSS Capitation Codes

Capitation Code	Description
89399	MLTSS Eligible Without Medicare – HCBS

79399	MLTSS Eligible With Medicare – HCBS

MLTSS: Managed Long-Term Services and Supports; HCBS: Home and Community-based Services.

Results by Category

Table 54 presents a summary based on file reviews of the MCOs' performance. Based on the audit tool, there were six categories of review elements (Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents). The results of individual review elements under each category were calculated and combined to produce a compliance score for each category.

Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 54**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 54: 2025 MLTSS HCBS Results by Category

Determination by Category 7/1/2024–6/30/2025[1]	ABHNJ Group C	ABHNJ Group D	ABHNJ Group E	ABHNJ Total	FC/WCHP Group C	FC/WCHP Group D	FC/WCHP Group E	FC/WCHP Total	HNJH Group C	HNJH Group D	HNJH Group E	HNJH Total	UHCCP Group C	UHCCP Group D	UHCCP Group E	UHCCP Total	WPNJ Group C	WPNJ Group D	WPNJ Group E	WPNJ Total	NJ Weighted Average[2]
Assessment	100.0%	97.9%	96.8%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	95.8%	100.0%	98.8%	100.0%	97.4%	94.9%	96.3%	92.0%	100.0%	98.0%	97.7%	98.1%
Member Outreach[3]	96.0%	92.0%		94.0%	76.0%	60.0%		68.0%	100.0%	76.0%		88.0%	24.0%	36.0%		30.0%	88.0%	72.0%		80.0%	72.0%
Face-to-Face Visits	92.6%	97.5%	94.5%	94.7%	97.9%	77.7%	90.3%	90.0%	77.8%	80.9%	70.5%	75.6%	74.8%	67.4%	70.2%	71.0%	91.7%	82.1%	83.1%	85.2%	83.6%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[4]	96.7%	97.7%	96.8%	97.0%	95.0%	95.4%	95.1%	95.1%	99.7%	97.2%	97.1%	97.7%	88.4%	91.2%	94.3%	92.2%	96.4%	95.1%	96.8%	96.3%	95.7%
Ongoing Care Management	84.8%	85.6%	85.6%	85.4%	91.8%	89.9%	83.5%	86.2%	98.9%	92.8%	97.6%	96.6%	75.3%	82.4%	75.8%	77.3%	83.0%	84.8%	79.5%	81.2%	85.6%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.6%	100.0%	99.4%	95.2%	91.8%	100.0%	96.7%	100.0%	100.0%	100.0%	100.0%	99.2%

[1] Group C: members new to managed care and newly eligible to MLTSS; Group D: current members newly enrolled to MLTSS; Group E: members enrolled in the MCO and MLTSS prior to the review period.

[2] The weighted average is the sum of all compliant charts (numerator) divided by the sum of all charts (denominator) and includes all three subpopulations.

[3] Member Outreach is not assessed for members in group E because Group E members are not new to MLTSS.

[4] Initial Plan of Care is assessed for Group C and Group D members. Ongoing Plans of Care are assessed for Group E members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E members.

The following MCOs scored **86% or above** at the total level, for all applicable MLTSS subpopulations for the following categories (**Table 54**):

- Assessment: Aetna, Fidelis, Horizon, United and Wellpoint.
- Member Outreach: Aetna and Horizon.
- Face-to-Face Visits: Aetna and Fidelis.
- Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans): Aetna, Fidelis, Horizon, United and Wellpoint.
- Ongoing Care Management: Fidelis and Horizon.
- Gaps in Care/Critical Incidents: Aetna, Fidelis, Horizon, United and Wellpoint.

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

- Member Outreach: Fidelis, United, and Wellpoint.
- Face-to-Face Visits: Horizon, United, and Wellpoint.
- Ongoing Care Management: Aetna, United, and Wellpoint.

Strengths and Opportunities for Improvement

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

ABHNJ

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

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

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

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

FC/WCHP

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

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

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

- Member Outreach (Groups C, D and Combined)
- Face-to-Face Visits (Group D)
- Ongoing Care Management (Group E)

HNJH

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

- Assessment (Groups C, D, E and Combined)
- Member Outreach (Groups C and Combined)

- Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) (Groups C, D, E and Combined)
- Ongoing Care Management (Groups C, D, E and Combined)
- Gaps in Care/Critical Incidents (Groups C, D, E and Combined)

Opportunities for improvement were noted in the following categories by population:
- Member Outreach (Group D)
- Face-to-Face Visits (Groups C, D, E and Combined)

UHCCP
UHCCP scored at or above 86% in the following categories by population:
- Assessment (Groups C, D, E and Combined)
- Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) (Groups C, D, E and Combined)
- Gaps in Care/Critical Incidents (Groups C, D, E and Combined)

Opportunities for improvement were noted in the following categories by population:
- Member Outreach (Groups C, D and Combined)
- Face-to-Face Visits (Groups C, D, E and Combined)
- Ongoing Care Management (Groups C, D, E and Combined)

WPNJ
WPNJ scored at or above 86% in the following categories by population:
- Assessment (Groups C, D, E and Combined)
- Member Outreach (Group C)
- Face-to-Face Visits (Group C)
- Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) (Groups C, D, E and Combined)
- Gaps in Care/Critical Incidents (Groups C, D, E and Combined)

Opportunities for improvement were noted in the following categories by population:
- Member Outreach (Groups D and Combined)
- Face-to-Face Visits (Groups D, E and Combined)
- Ongoing Care Management (Groups C, D, E and Combined)

2025 MLTSS HCBS Performance Measures Findings
In review of this year's NJ weighted average scores that include all three MLTSS subpopulations (July 1, 2024–June 30, 2025), among all five MCOs, the results ranged from 40.0% to 100.0% across all seven MLTSS PMs (**Table 55**).

Results by Category
Population-Specific findings are presented in **Table 55** which present MCOs' results on the following 2025 MLTSS HCBS Performance Measures Findings: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 55**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 55: 2025 Results of MLTSS HCBS Performance Measures

Performance Measure for Review Period July 1, 2024, to June 30, 2025	Group[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	NJ Weighted Average[6]
#8. Plans of Care established within 45 days of MLTSS enrollment.[4]	C	84.0%	88.0%	100.0%	44.0%	80.0%	79.2%
	D	92.0%	96.0%	92.0%	36.0%	72.0%	77.6%
	E						
	TOTAL	88.0%	92.0%	96.0%	40.0%	76.0%	78.4%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[5]	C						
	D						
	E	100.0%	96.0%	100.0%	91.8%	100.0%	97.5%
	TOTAL	100.0%	96.0%	100.0%	91.8%	100.0%	97.5%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	C	100.0%	N/A	100.0%	50.0%	N/A	92.3%
	D	100.0%	N/A	100.0%	66.7%	87.5%	92.9%
	E	82.4%	88.9%	97.0%	84.6%	70.5%	83.4%
	TOTAL	87.0%	88.9%	98.0%	77.8%	73.1%	85.4%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	D	100.0%	100.0%	100.0%	100.0%	96.0%	99.2%
	E	100.0%	100.0%	100.0%	100.0%	96.0%	99.2%
	TOTAL	100.0%	100.0%	100.0%	100.0%	96.9%	99.4%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	D	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	C	100.0%	100.0%	100.0%	82.4%	100.0%	96.7%
	D	100.0%	100.0%	100.0%	91.3%	100.0%	98.2%
	E	97.9%	100.0%	100.0%	95.2%	100.0%	98.6%
	TOTAL	98.9%	100.0%	100.0%	91.5%	100.0%	98.1%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	C	100.0%	100.0%	100.0%	92.0%	100.0%	98.4%
	D	100.0%	100.0%	100.0%	92.0%	100.0%	98.4%
	E	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	TOTAL	100.0%	100.0%	100.0%	96.0%	100.0%	99.2%

[1] Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.

[2] Members who did not have a documented change in condition during the study period are excluded from this measure.

[3] Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4] Group E Members are excluded from this measure as they are not new to MLTSS.
[5] Group C and Group D Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.
[6] The weighted average is the sum of all compliant charts (numerator) divided by the sum of all charts (denominator) and includes all three subpopulations.
N/A: Not Applicable. There were no Members who met criteria for this measure.

The following MCOs scored ***86% or above*** at the total level, for all applicable MLTSS subpopulations for the following MLTSS PMs (**Table 55**):

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment: Aetna, Fidelis, and Horizon.
- **PM #9.** Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination: Aetna, Fidelis, Horizon, United, and Wellpoint.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition: Aetna, Fidelis, and Horizon.
- **PM #10.** Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment: Aetna, Fidelis, Horizon, United, and Wellpoint.
- **PM #11.** Plans of Care for MLTSS Members are developed using "Person-Centered Principles": Aetna, Fidelis, Horizon, United, and Wellpoint.
- **PM #12.** MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan: Aetna, Fidelis, Horizon, United, and Wellpoint.
- **PM #16.** MCO provided training to MLTSS Member on identifying/reporting Critical Incidents: Aetna, Fidelis, Horizon, United, and Wellpoint.

The following MCOs scored ***below 86%*** at the total level, for all applicable MLTSS subpopulations for the following MLTSS PMs (**Table 55**):

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment: United and Wellpoint.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition: United and Wellpoint.

2025 MLTSS Care Management and Continuity of Care Annual Assessment

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Annually, DMAHS evaluates MCO performance against these requirements through its EQRO contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of a pre-offsite review of documentation provided by the five MCOs, as evidence of compliance of the standards under review; interviews with key MCO staff (held remotely in December 2025), and post-offsite evaluation of documentation and offsite activities.

To assist in submission of the appropriate documentation, IPRO developed the *NJ 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.

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

The MLTSS Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS CM programs

for enrollees who may benefit from these services in accordance with State requirements. The rating scale for Met and Not Met elements is presented in **Table 56.**

Table 56: Rating Scale for the MCO MLTSS Annual Assessment Review of Care Management

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

MLTSS: Managed Long-Term Services and Supports; MCO: Managed Care Organization.

There were 10 contractual provisions in the 2025 MLTSS CM category. **Table 57** presents the total compliance scores, which were 100% for all five MCOs.

Table 57: Compliance Scores for the 2025 MLTSS Care Management and Continuity of Care Annual Assessment Elements

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	10	10	0	100%
FC/WCHP	10	10	0	100%
HNJH	10	10	0	100%
UHCCP	10	10	0	100%
WPNJ	10	10	0	100%

MLTSS: Managed Long-Term Services and Supports; MCO: Managed Care Organization.

Table 58 presents the summary of findings for each element reviewed during the 2025 MLTSS Annual Assessment Care Management Audit.

Table 58: Summary of Findings for 2025 MLTSS Care Management and Continuity of Care Audit

2025 Annual Assessment CM Element[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM18b	X	X	X	X	X
CM28	X	X	X	X	X
CM29	X	X	X	X	X
CM30	X	X	X	X	X
CM31	X	X	X	X	X
CM32	X	X	X	X	X
CM34	X	X	X	X	X
CM36	X	X	X	X	X
CM37	X	X	X	X	X
CM38	X	X	X	X	X
Total Elements = 10	**10**	**10**	**10**	**10**	**10**
Compliance Percentage	**100%**	**100%**	**100%**	**100%**	**100%**

[1] Letter x (X) indicates "Met", and hyphen (-) indicates "Not Met" or "Not Reviewed".

No deficiencies were identified in the MLTSS 2025 Care Management and Continuity of Care Annual Assessment Review (**Table 58**).

MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 59-Table** 63 display the MCOs' responses verbatim to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

ABHNJ Response to Previous EQR Recommendations

Table 59 displays ABHNJ's progress related to the *State of New Jersey DMAHS, Aetna Better Health of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2025,* as well as IPRO's assessment of ABHNJ's response.

Table 59: ABHNJ Response to Previous EQR Recommendations

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ABHNJ should address the Core Medicaid PIP validation elements that were determined to be not met or partially met.	The barrier analysis was updated as part of a review of the PCP utilization data as it was found that a significant number of members were seeing a PCP other than their assigned PCP. However, it was also noted that a significant percentage of members still are not seeing any PCP on an annual basis. ABHNJ is working on a project to reassign members to a PCP other than their assigned PCP based on receiving a claim from the new PCP. In addition, the Plan will continue telephonic outreach to both adults and children who do not have a claim within the prior 12 months for a visit with their PCP to encourage/assist with scheduling an appointment. To address less than optimal results with the PIP focused on improving EPSDT rates, the Plan is seeking direct member and community partner feedback on what are some of the barriers they have encountered in getting children in for well child visits and immunizations. The Plan will consider implementing additional interventions if new barriers are identified. IVR outreach also continues for children to provide education about the importance of scheduled/attending regular visits and the safety of vaccines as well as telephonic outreach to families of children who have not been in for a visit in 12 months or longer to encourage/assist with scheduling an appointment. Finally, ABHNJ is working to get large provider groups that treat both adults and children signed on to Aetna Value Initiative for Providers (AVIP) contracts. The AVIP program prioritizes patient health outcomes by offering incentives to providers for the coordinated delivery of high-quality, evidence-based health care which include scheduling of initial appointments for new adult and pediatric enrollees	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	and getting children in for well child visits and immunizations. Adult preventive care may also soon be added as a measure.	
ABHNJ should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists across all counties except Essex, Hudson, Morris, Passaic, Somerset, and Union.	ABHNJ Network Management has developed a targeted recruitment strategy to address gaps in care across specific pediatric specialties. This is reviewed biweekly to focus on pediatric provider recruitment; efforts are tracked using the ABHNJ Recruitment Tracker Template. The Network team has contracted with various pediatric specialists over the last year, which has increased the network across numerous counties where there were deficiencies. Network Management works with both the Provider Data Services and Informatics teams to identify and update any provider specialty mapping and system inaccuracies to improve data output.	Remains an opportunity for improvement
ABHNJ should continue to address hospital deficiencies in Salem County.	ABHNJ has identified two (2) hospitals in Salem County that are participating in the network. They are Inspira Medical Center Elmer and Inspira Medical Center Mannington, currently there is no deficiency in the network for hospitals in Salem County.	Addressed
ABHNJ should continue to expand the MLTSS network to include at least two providers in every County for Private Duty Nursing.	ABHNJ continues to work on increasing its MLTSS network. The recruitment of Private Duty Nursing (PDN) has been a key focus across the State with emphasis on the following counties Atlantic, Cape May, Cumberland and Salem. We have been successful with recruitment efforts in Hunterdon, Somerset and Warren counties, which no longer have deficiencies. Recruitment of PDN in the remaining counties will continue to be a primary goal. However, we have an abundance of servicing PDN that provides service to ABHNJ members statewide.	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ABHNJ should focus on improving appointment availability for Specialists, and Behavioral Health Providers, as well as after-hours non-compliance.	ABHNJ will continue to provide education on state requirements regarding appointment accessibility standards. The following are the activities implemented by the plan: 1. ABHNJ has improved its provider communications, including appointment and availability standards. This communication was included with the failed notification letters. 2. Provider Relations will continue to include the importance of appointment accessibility discussions during provider office visits, details will be added to newsletters, and faxes will be sent periodically. 3. All failed providers will be outreached via phone calls and/or office visits by the 4th quarter of 2025. 4. There will be a comparison and analysis of failed providers from 2023 and 2024 with an initiation of a Corrective Action Plan. For providers who fail to adequately address issues in the corrective action plan they will be referred to the plan's provider performance workgroup to assess performance.	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ABHNJ should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as most failure reasons resulted from the provider not being at the listed site.	There are several provider directory projects aimed at improving the accuracy of provider data. These initiatives include: Trend Analysis for Data Accuracy: Conducting outreach calls to validate provider information, establishing a baseline accuracy score, running targeted queries to detect data inaccuracy trends, and updating QNXT based on these findings. Cross-Program Data Alignment: Leveraging Commercial and Medicare data to enhance Medicaid accuracy by comparing directory entries with EPDB, performing phone outreach, and updating the Medicaid system (QNXT) accordingly. AI and Web Scraping: Using automated tools to reduce manual outreach by validating provider directory information through official provider websites. Vendor Solutions: Integrating data from vendors like Quest to make updates that do not require additional validation. Directory Plan Structure and Rules: Defining and documenting directory requirements by state, including standard requirements and noting state-specific variations with corresponding coding to ensure compliance.	Addressed
ABHNJ should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.	Through its credentialing and recredentialing process, the credentialing team validates board certification status for all providers prior to inclusion in the online directory. Providers are required to attest to the accuracy of their board certification status during initial and recredentialing.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ABHNJ should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.	ABHNJ utilizes both the Special Needs Provider Survey Form and the Provider Credentialing Roster spreadsheet to identify providers with experience serving adults and children with special health care needs. This information is entered into ABHNJ's business operating system (QNXT) and reflected in the provider directory to ensure visibility and accessibility for members seeking specialized care.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	ABHNJ completes barrier analysis for each of the measures that are not meeting the NCQA National 50th percentile benchmark. While reviewing the barriers for each measure, as an interdisciplinary team, we discuss interventions that will address each measure that has not met the benchmark. The ABHNJ quality team, meets monthly with an interdisciplinary team, for each of our HEDIS measure related workgroups. We hold workgroups for our pregnant members and women's health, children and adolescent care, and behavior health and pharmacy measures. ABHNJ quality continues to hold meetings with our Provider Groups to work together to ensure our members are meeting the measure goals, while continuing to get the care they need.	Addressed
The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that perform below the 50th percentile.	In 2024, ABHNJ submitted a comprehensive CAHPS Workplan to the State, which included barrier analysis and targeted interventions for each composite and measure that fell below the NCQA 50th percentile for both Adult and Child with CCC populations. An interdisciplinary CAHPS workgroup regularly meets to review the progress of these interventions. To boost member engagement, the Plan sent a CAHPS pre-notification mailer to all heads of household in January 2024, replacing the standard pre-notification cards from the CAHPS vendor. The Plan also continues to conduct a Pre-CAHPS (mock) survey via IVR to	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	identify actionable insights by provider group and geographic area, and follows up with providers to address specific barriers and improvement opportunities. Ongoing call listening sessions are held to review randomly selected member calls for improvement opportunities, and meetings with Call Center leadership ensure NJ-specific training for staff serving ABHNJ members, covering Plan priorities, contract updates, and staff questions. In Q1 2025, the Plan began monitoring provider calls to assess first-call resolution and the accuracy of information provided by call center representatives. Additionally, ABHNJ employees were assigned CAHPS training— "How your work makes a difference to our members"—in 2024, with completion tracked through regular reports. The Plan's CEO also led provider-focused sessions to identify improvement areas and evaluate the accuracy of information shared with both members and providers.	
ABHNJ should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • GP: Identification, and all CM element specific deficiencies noted in the review.	ABHNJ implemented Eliza Engage and Transfer warm call transfers when a member is reached to transfer and complete an Initial Health Screener with a live representative. Supervisors meet with care managers at minimum monthly to review compliance via dashboards, audit trends and coach staff as needed. Trends in non-compliance trends may result in formal remediation.	Addressed
ABHNJ should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DDD: Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	ABHNJ ICM conducted a Back to Basics Training in Q1 of 2025 that consisted of care management functions as it relates to care management of the DDD population. Supervisors meet with care managers at minimum monthly to review compliance via dashboards, audit trends and coach staff as needed. Trends in non-compliance trends may result in formal remediation. ABHNJ leadership utilizes compliance dashboards for timeliness metrics. Internal audits are utilized for CM performance, coaching, and to proactively identify improvement areas.	Remains an opportunity for improvement
ABHNJ should address the deficiencies noted in	ABHNJ ICM conducted a Back to Basics Training in Q1 of 2025 that consisted of care management functions as it relates to care management of the DCP&P population.	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
the Core Medicaid - 2024 CM Review in the following areas: • DCP&P: Preventive Services, and all CM element specific deficiencies noted in the review.	Supervisors meet with are managers at minimum monthly to review compliance via dashboards, audit trends and coach staff as needed. Trends in non-compliance trends may result in formal remediation. ABHNJ leadership utilizes compliance dashboards for timeliness metrics. Internal audits are utilized for CM performance, coaching, and to proactively identify improvement areas.	
ABHNJ should address the deficiencies noted in the MLTSS – HCBS 2024 CM Review for elements within groups that scored below 86%.	**IPRO Recommendations: Face to Face Visits or Telephonic Monitoring:** Group C: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling. 1. NJCA are reviewed internally prior to submission to OCCO. Reviewer ensures that documentation confirms that PACE was discussed with the Member during Options Counseling. 2. ABH conducts internal audits of NJCA submitted for quality assurance review, including validation that PACE has been offered. **IPRO Recommendations: Ongoing Care Management:** Group C and Group E: ABHNJ should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). Group C and Group D: For Members who are discharged to an HCBS setting, ABHNJ should ensure the onsite review occurs within ten (10) days of discharge. Group C and Group E: 1. MLTSS Leadership completes analysis based on membership and requests positions accordingly.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. Supervisors meet with CM at minimum monthly to review compliance. Supervisors review members "coming due" and ensure members are scheduled within 90 days of previous visit, unless there is documentation of a member-directed reason. If members were not seen face to face timely, the cause is reviewed and if not member-driven, CM receives reeducation. Trends in non-compliance may result in formal remediation. 3. CM must demonstrate during their scheduled 1-1 competence in appropriately scheduling member visits within visit timeframes. Dashboard reeducation is held with CM as needed with Supervisor or Clinical Trainer. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. 4. ABH Leadership utilizes Executive dashboard data to guide CM during 1-1 on their timeliness with visits; CM are provided reeducation and coaching as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. 5. ABH Leadership utilizes Productivity Dashboard data to guide CM during 1-1 on the quantity of visits completed; CM are provided reeducation and coaching as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. Group C and Group D: 6. Internal tracking to monitor timeliness of post discharge visits and notification from UM Team.	
ABHNJ should address all deficiencies noted in the MLTSS – NF/SCNF 2024 CM Review for elements that scored below 86%.	**IPRO Recommendations: Ongoing Care Management:** ABHNJ MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members). 1. MLTSS Leadership completes analysis based on membership and requests positions accordingly.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. Supervisors meet with CM at minimum monthly to review compliance. Supervisors review members "coming due" and ensure members are scheduled within 90/180 days of previous visit (dependent on placement), unless there is documentation of a member-directed reason. If members were not seen face to face timely, the cause is reviewed and if not member-driven, CM receives reeducation. Trends in non-compliance may result in formal remediation. 3. CM must demonstrate during their scheduled 1-1 competence in appropriately scheduling member visits within visit timeframes. Dashboard reeducation is held with CM as needed with Supervisor or Clinical Trainer. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. 4. ABH Leadership utilizes Executive dashboard data to guide CM during 1-1 on their timeliness with visits; CM are provided reeducation and coaching as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. 5. ABH Leadership utilizes Productivity Dashboard data to guide CM during 1-1 on the quantity of visits completed; CM are provided reeducation and coaching as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources. **IPRO Recommendations: PASRR Communications for Transitions to NF/SCNF:** ABHNJ MLTSS Care Managers should ensure communication of PASRR Level II to OCCO is documented by the Care Manager (within 1 business day of receipt of determination). 1. MLTSS Leadership receives results from the ABH Audit Team monthly. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	IPRO Recommendations: Performance Measure #8: ABHNJ's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS. 1. MLTSS Leadership receives results from the ABH Audit Team monthly. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. For sustained trends in non-compliance, CM may be placed on a formal PIAP through CVS Human Resources.	

[1] **Addressed**: Managed Care Organization (MCO)'s Quality Improvement (QI) Corrective Action Plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2025. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

FC/WCHP Response to Previous EQR Recommendations

Table 60 displays FC/WCHP's progress related to the *State of New Jersey DMAHS, Fidelis Care Annual External Quality Review Technical Report FINAL REPORT: April 2025,* as well as IPRO's assessment of FC/WCHP's response.

Table 60: FC/WCHP Response to Previous EQR Recommendations

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Fidelis Care should address the Core Medicaid PIP validation elements that were determined to be not met or partially met.	Fidelis Care acknowledges this recommendation and commits to fully addressing all core Medicaid PIP validation elements that were identified as not met or partially met. We are in the process of reviewing the validation findings in detail and will incorporate corrective actions into our final phase activities and future PIP planning. For partially met elements, Fidelis Care will strengthen documentation to better demonstrate alignment with state and CMS requirements. For elements not met, Fidelis Care is working cross-functionally to implement necessary process improvements and ensure full compliance moving forward. These steps will help enhance the quality, clarity, and impact of our PIP submissions.	Remains an opportunity for improvement
Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric	Fidelis Care monitors its Pediatric Primary Care Provider (PCP) network to ensure our members have access to care through Geo Access reports generated and reviewed quarterly. Fidelis Care's Network Management team identifies providers to target sources for lead generation	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
PCPs in Sussex County.	for recruitment through regular bi-weekly meetings to review Network Adequacy. In Burlington, Cape May and Warren Counties, Fidelis Care's overall provider network meets adequacy; however, due to Fidelis Care's small membership in these counties, deficiencies arise when applying the State's active provider criteria to its network in these counties. In Sussex County, Fidelis Care continues its ongoing discussions with Advocare pediatrics; if Fidelis Care reaches an agreement with this group, the Sussex County deficiency would be resolved. No additional providers exist in Sussex County to resolve this deficiency. Fidelis Care is not currently approved to provide NJ FamilyCare coverage in Hunterdon County due to the refusal of Hunterdon Medical Center to add any new NJ FamilyCare plans. Fidelis Care regularly checks in with Hunterdon Medical Center to see if they have changed their position on adding new NJ FamilyCare plans.	
Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists across all Counties.	Fidelis Care's Provider Network team plays a critical role in ensuring members have consistent and adequate access to care. To monitor this, the team relies on quarterly Geo Access reports, which help assess the reach and strength of the provider network across operational counties. These reports are instrumental in identifying gaps and guiding strategic decisions. Complementing this effort, the Network Management team convenes bi-weekly to evaluate network adequacy and pinpoint providers for lead generation. This collaborative approach ensures that the network remains responsive to member needs and regulatory standards. In Q2 of 2025, the application of updated Geo Access guidelines revealed a notable increase in Pediatric Specialty Gaps compared to the previous year. Specifically, 146 gaps were identified based on time and distance standards, while 56 remained active and unresolved. Fidelis Care operates across a broad footprint in New Jersey, including Atlantic, Bergen, Burlington, Cape May, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, and Warren counties. Within	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	these regions, gaps were identified in a wide range of pediatric specialties, including Adolescent Medicine, Child Development, Pediatric Allergy and Immunology, Pediatric Cardiology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Neonatology, Pediatric Emergency Medicine, Plastic Surgery, Pediatric Oncology, Pediatric Psychiatry, Pediatric Pulmonary, Pediatric Rheumatology, Pediatric Sleep Medicine. In response to these challenges, Fidelis Care submitted waiver requests for 202 Pediatric Specialty Gaps in Q2 2025. These waivers were based on the inability to locate qualified pediatric providers within the required geographic areas, despite exhaustive search efforts. The team utilized multiple resources to identify potential providers, including NJMMIS, Google Search, competitor websites, and the national NPI registry. Although the American Board of Pediatrics website was reviewed, it did not support provider searches by board certification, limiting its utility in the process.	
Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Hudson County.	Fidelis Care collaborates with its dental vendor, Liberty Dental Plan, to enhance the network of general dentistry and dental specialty providers. The Liberty Dental Network Management recruitment team evaluates provider offices to ensure physical access for members with disabilities and reviews cultural background factors to include, but not limited to ethnicity, country of origin, customs, and documented community outreach activities. Information gathered through these sources is reviewed and analyzed for consideration in increasing our provider network. The Network Management team also works to develop recruitment strategies to ensure the standards for provider to member ratio are compliant with program, state, and federal requirements. Provider to Member ratios is monitored on an ongoing basis by the Provider Relations team with support from their Analysts. These ratios and capacity limits are considered during a variety of activities carried out by the Provider Relations team which includes, but are not limited to Dental Home assignment, Provider terminations and/or member transfers, recruitment, and network growth activities. Provider recruitment logs are reviewed and monitored monthly.	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	To improve the network in Hudson County, Liberty Dental Plan reviewed their claim database of out of network claims to identify providers for recruitment. Liberty Dental Plan has made network improvements in Hudson County by contracting the following six offices: - Urban Dental & Braces (Bayonne) Effective 8/21/2025 - Smilekraft Dental (Jersey City), Effective 6/19/2025 - Armstrong Dental Studio of Bayonne (Bayonne), Effective 5/16/2025 - Heights Dental Group (Jersey City), Effective 5/13/2025 - Denta Glow Corp (Jersey City), Effective 4/4/2025 - Bergen Dental Aesthetics (North Bergen), Effective 1/21/2025 Network Management Team also reviewed the provider's demographic information to ensure accurate representation of providers in the current directory. Lastly, Liberty Dental Plan will continue to review competitor NJ FamilyCare directories to identify additional leads for recruitment.	
Fidelis Care should focus on improving appointment availability for Adult PCPs, Pediatric PCPs, OB-GYNs, Specialists, Behavioral Health Prescribers, Behavioral Health Non-Prescribers, as well as after-hours non-compliance.	Fidelis Care maintains a strong focus on improving Appointment and After-Hours Availability results. During the audit period, two surveys were conducted: Semi I 2024 Medicaid and Semi II 2024 Medicaid. While the Semi I 2024 Medicaid survey results, released in July 2024, showed improvements, most measures remained below the 90% benchmark. On September 23, the team meets to review the updated list of failed providers and determine the next steps. Efforts to improve After-Hours and appointment availability with participating providers continue. Despite ongoing audits, Behavioral Health (BH) providers consistently show deficient scores in appointment availability standards. A key contributing factor is limited staffing within many BH practices, where providers often manage their own scheduling with minimal administrative support. This leads to a lack of awareness regarding appointment availability requirements. To address this	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	issue, Fidelis Care updated its Behavioral Health Provider Orientation materials in Q4 2024 to clearly outline appointment availability standards and emphasize the importance of timely access to care. The Semi II 2024 results, released in May 2025, showed a decrease in performance across several standards. Based on these results, Fidelis Care developed enhanced outreach efforts to reinforce appointment availability expectations across the provider network, including a recurring "email blast" initiative. These periodic emails outline appointment availability requirements and encourage providers to share the information with their scheduling staff. The goal is to ensure continued compliance and improve patient access to care. This intervention continued into third quarter and remains an ongoing strategy to increase awareness and adherence to standards across a broader segment of the provider network. Fidelis Care remains committed to improving After-Hours access and appointment availability across its provider network. These areas continue to be central to provider engagement and compliance efforts.	
For the Core Medicaid Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations PIP, as this PIP has moved into the final phase, Fidelis Care should continue to develop more robust interventions to improve performance indicators for this and future PIPs.	Fidelis Care agrees that strengthening interventions is essential to improving EPSDT performance, particularly for Immunizations and Well Child visits. The team actively explores additional targeted strategies, including data-driven outreach to members with care gaps, enhanced provider engagement and collaboration, and expanded use of digital communication. Although the quarterly member newsletter highlights the importance of preventive care, it is not introduced as a new intervention. These efforts build on existing initiatives and support sustainable improvements and future Program Improvement Projects (PIPs).	Addressed
For the MLTSS Improving Coordination of Care and Ambulatory Follow-up After	Fidelis Care identified barriers to care including frequent Emergency Department utilization, care management challenges, limited access to services, high disease burden, geographic barriers, and limited member awareness of available support. To address these issues, Fidelis Care's	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations PIP, as this PIP has moved into the final phase, Fidelis Care should continue to develop more robust interventions to address the barriers identified for this and future PIPs.	Care Management team implemented the Performance Improvement Project (PIP) focused on Follow-up After Mental Health Hospitalization for members in the MLTSS Home and Community-Based Services (HCBS) population. All HCBS members now receive follow-up within 10-days of discharge for both medical and behavioral inpatient admissions, including a comprehensive post-discharge assessment to address follow-up needs and identify Social Determinants of Health. The final PIP results demonstrated 100% compliance. Building on these outcomes, Fidelis Care is developing additional interventions to sustain and strengthen results for future PIPs, including expanding member education on available supports, enhancing data-sharing with providers to improve care transitions, and refining care management protocols for high utilizers. These steps ensure continuous improvement beyond compliance and align with the requirement to implement robust interventions for this and future PIPs.	
Fidelis Care should adhere to Waiver Year End (WYE) timeline and submit the Care of Older Adults (COA) MLTSS performance measure timely.	Fidelis Care took the following concrete steps to address and close gaps in the Waiver Year End (WYE) timeline and ensure timely submission of the Care of Older Adults (COA) MLTSS performance measure: Actions include: - A designated team member assumes oversight responsibilities to drive accountability and progress - Conducting a thorough review to identify the root cause - Engaging subject matter experts to support improvement efforts - Strengthening cross-functional collaboration - Establishing a monthly review process for reports and dashboards to ensure timely submissions for MY2024 record collection for PM52 and PM53 - These actions will help Fidelis Care stay on track to meet State requirements and successfully complete the measure validation process.	Addressed
Fidelis Care should update the Member	Fidelis Care conducts a biannual review of contract changes and monitors updates relevant to the Member	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Handbook to reflect all Contract requirements.	Handbook and incorporates these updates into its member handbook submission for the following year. To ensure timely progress on incorporating new contract requirements into the member handbook, Fidelis Care conducts bi-weekly status reviews with stakeholders and tracks updates until finalization and submission of its annual Member Handbook update. As part of this process, the team confirms that all appropriate contract changes are implemented and reflected in the Member Handbook.	
Fidelis Care should ensure that policy updates should be applicable during the review period and provided to the EQR for review.	Fidelis Care's Audit Team will include a review of each policy submitted in support of its EQRO elements to validate that each policy is effective during the review period.	Addressed
Fidelis Care should ensure that the Disenrollment Policy incorporates the specific language regarding "Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but remain in the custody of DCP&P", and policy updates should be applicable during the review period and provided to the EQR for review.	Fidelis Care added specific language related to "Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but remain in the custody of DCP&P" in the most recent annual update of its Disenrollment Policy.	Addressed
Fidelis Care should ensure the MLTSS Disenrollment Request Step Action explicitly outlines the written notification requirements for members who refuse consent for clinical eligibility reassessment or face-to-face visits, despite	Fidelis Care updated its MLTSS Disenrollment Request Step Action to clarify the written notification requirements for members who refuse consent for clinical eligibility reassessment or face-to-face visits, despite having received counseling and a minimum of two attempts to obtain consent.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
having received counseling and a minimum of two attempts to obtain consent, and policy updates should be applicable during the review period and provided to the EQR for review.		
Fidelis Care should ensure MLTSS Disenrollment Request Step Action clearly specifies that the Care Manager must initiate a face-to-face visit within 10 business days, and policy updates should be applicable during the review period and provided to the EQR for review.	Effective September 2024, Fidelis Care updated its MLTSS Disenrollment policy to clarify the requirement for initiating a face-to-face visit within 10 business days of receiving a member's agreement to comply with MLTSS program requirements.	Addressed
Fidelis Care should have a process in place to appropriately pull the correct Credentialing and Re-Credentialing files for MLTSS providers. Fidelis Care should also ensure the provider files will be QA'd before submitting them to the EQRO for review. Fidelis Care should ensure all MLTSS providers (including Skilled Nursing Facilities) submit an attestation as evidence for conducting criminal background checks	Fidelis Care maintains a structured process to accurately pull Credentialing and Re-Credentialing files for Managed Long Term Services and Supports (MLTSS) providers. To prevent errors, all files are now reviewed and approved by the Credentialing team prior to submission, ensuring appropriate quality assurance (QA) controls before delivery to the External Quality Review Organization (EQRO). The prior issue involving inclusion of dental files without Credentialing approval has been corrected through this process change. In addition, Fidelis Care requires all MLTSS providers, including Skilled Nursing Facilities, to submit an attestation confirming completion of criminal background checks in accordance with contract requirements. The four missing attestations noted during the audit were resolved during the virtual on-site review, and compliance has been reinforced through refresher training, updates to the Credentialing Provider SharePoint site, and integration into the Audit Tool to ensure consistent adherence going forward.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
per Contract requirements.		
Fidelis Care should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.	Fidelis Care continuously improves the accuracy of its provider directory through enhanced communication and process updates. Although procedures are in place, many providers do not report profile changes within the required 30-day timeframe, as outlined in their contracts. To address this, Fidelis Care introduced provider portal notifications that prompt providers to update their information. Quarterly audits conducted help identify outdated records, which are then verified and updated by Fidelis Care's Provider Data Coordinators. These findings may result in directory removal or network termination. State-mandated spot checks are performed on 50% of the network through direct outreach and demographic submissions. The Network Operations and Provider Relations teams actively monitor and update the Find-a-Provider tool to ensure members have access to accurate provider information.	Addressed
Fidelis Care should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.	Fidelis Care verifies board certification status using data from the American Board of Medical Specialties (ABMS), applying this information based on each provider's current certification. In alignment with New Jersey regulations, board certification is continuously monitored to ensure accuracy and compliance.	Addressed
Fidelis Care should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.	Fidelis Care equips providers to recognize and address the culturally diverse needs of the members they serve. This includes maintaining accessible facilities and offering specialized equipment to support individuals with disabilities and special needs. As part of Fidelis Care's contracting and credentialing process, providers complete a Special Needs Survey and an ADA Compliance Survey. These tools help assess provider capabilities and ensure the delivery of inclusive, accessible care. To support this commitment, Fidelis Care offers ongoing training for providers who work with members with special needs. Updated resources and guidance are regularly	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	shared through virtual and in-person visits conducted by our Provider Relations and Quality Improvement teams.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, FC/WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Fidelis Care aims to increase HEDIS® rates to meet or exceed the NCQA 50th percentile. In alignment with contractual and State/IPRO requirements, Fidelis Care submits an annual quality work plan for measures where clinical performance falls below this benchmark. To support improvement efforts, Fidelis Care conducts quality-focused education visits with providers. These visits include guidance on coding and claims submission, review of member care gaps, and distribution of Provider Toolkits containing HEDIS measure details, best practice guidelines, and medical record documentation standards. The Quality team also provides laminated coding sheets to billing staff to support accurate and timely claims processing. Fidelis Care's Quality team coordinates efforts to close care gaps, educate providers on their importance, and assist with care gap reports and missed opportunities. This process includes medical record reviews to identify coding deficiencies, followed by re-education for providers and practice managers. Monthly monitoring of provider visits is conducted through QI metric reports. The Preventive Service Outreach (PSO) program supports Medicaid measures by making outbound calls to non-compliant members, educating them on the importance of preventive services, and assisting with appointment scheduling. In response to the ongoing lead crisis in New Jersey's water system, Fidelis Care implemented a lead screening initiative that includes educational text messages to parents and guardians. Targeted in-person visits to pediatric providers focus on improving lead screening, well-child visits, and immunization rates. The Pediatric Taskforce meets monthly with providers to review performance, documentation, scheduling opportunities, and best practices. An FQHC quality lead ensures that all New Jersey FQHCs follow streamlined, effective quality practices and engage with their communities. Additionally, the Quality team regularly collaborates with interdepartmental teams—	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	including Behavioral Health, PHCO, Care Management, and Network Operations—to review performance, provider engagement, and member-facing initiatives, and to develop strategies that improve quality outcomes.	
The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	The Fidelis Care HEDIS team reviews and aligns internal processes with the annual guidance issued by DMAHS at the start of each performance measure season. This ensures ongoing compliance and accuracy in reporting across all applicable measures.	Addressed
The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile.	Fidelis Care aims to improve Adult and Child CAHPS® scores to meet or exceed the NCQA 50th percentile. The CAHPS work plan is organized by measure and includes current and prior year rates, identified barriers, planned interventions, goals, monitoring strategies, responsible parties, and performance metrics. Planned and ongoing interventions include targeted member engagement through concierge outreach and service recovery, along with proactive education on dual benefits and care navigation. Customer service calls are regularly reviewed to identify training opportunities and enhance first-call resolution. CAHPS and Provider Satisfaction Survey data are analyzed to identify trends and inform actionable interventions. The Quality and Provider Relations teams conduct provider visits to address network access, availability, and care coordination, while distributing updated provider toolkits that include HEDIS, CAHPS/HOS, and quality standards. The Quality Concierge Engagement Team (QCET) plays a central role in executing outreach strategies and resolving member experience barriers in real time. CAHPS strategies and progress are reviewed during monthly Member Experience Steering Committee (MESC) meetings to ensure cross-departmental alignment and oversight. CAHPS workgroups meet regularly and as needed to track progress and outcomes. All provider- and member-facing teams complete annual CAHPS training to ensure consistent, high-quality experience for members.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • GP: Identification, and all CM element specific deficiencies noted in the review.	To address deficiencies identified in the 2024 Core Medicaid Care Management review for General Population members and maintain compliance at or above 86%, Fidelis Care conducts daily reviews of the Real-Time Discharge Planning and Utilization Management Census Reports to ensure post-discharge needs are addressed within 24–48 hours; participates in Length of Stay rounds with Shared Services to support timely engagement; monitors assessment and care plan completion through the Non-MLTSS Report; issues individualized 21-day reminders to Care Managers; and enforces ongoing supervisory oversight through one-on-one meetings, team meetings, ad hoc huddles, and quarterly all-associate sessions. These combined measures ensure timely, compliant completion of all care management requirements.	Remains an opportunity for improvement
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DDD: All CM element specific deficiencies noted in the review.	To maintain an 86% compliance rate with the elements identified in the 2024 Core Medicaid Care Management review for DDD members, the Care Management team implements a multi-faceted strategy focused on timely monitoring, proactive engagement, and consistent communication. - The team holds monthly meetings with Fidelis Care's dental vendor to review the status of recently referred and active members. All care and scheduling issues are addressed and followed up by the Care Management team. Dental care is now a core component of every member's care plan. - Oral Health Reminder letters are sent bi-annually to members who have not utilized dental services. Additionally, the Relay text message campaign reaches out to these members monthly. - The team resumes direct outreach calls to Medicaid liaisons while continuing email communication, improving collaboration and response rates. - Leadership uses the Non-MLTSS Report to track the timeliness of care management assessments and care plan completions. - To support timely documentation, the supervisor sends individualized 21-day email reminders to	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	each Care Manager, prompting completion of assessments and care plans by their due dates. - Monthly 1:1 sessions are scheduled with each Care Manager. - As-needed huddles are held to address urgent issues or updates. - Quarterly all-associate meetings ensure alignment and promote the sharing of best practices.	
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DCP&P: All CM element specific deficiencies noted in the review.	Fidelis Care is committed to addressing all deficiencies identified in the Core Medicaid – 2024 Care Management (CM) Review related to the Division of Child Protection and Permanency (DCP&P) population. To ensure timely care management assignments and compliance, Fidelis Care leverages the Juvenile Management Division (JMD) – Division of Developmental Disabilities (DDD) – Division of Child Protection and Permanency (DCP&P) Report to track new enrollees and monitor performance. This process supports maintaining compliance at or above the 86% threshold across key review elements. The management team monitors completion of initial assessments and care plans through the Non–Managed Long Term Services and Supports (Non-MLTSS) Report, which supports adherence to required timeliness standards. To reinforce compliance, Fidelis Care utilizes a monthly scorecard and a 21-day automated reminder system that sends email alerts to care managers as assessment and care plan deadlines approach. Supervisors conduct monthly one-on-one sessions, regular team meetings, and ad hoc huddles to address performance gaps, provide coaching, and reinforce expectations. Further, Fidelis Care's corporate Shared Services team conducts monthly audits to validate quality and compliance. Biweekly interdisciplinary case rounds are also held to review member needs, identify gaps, and ensure appropriate interventions are implemented.	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Through these combined measures, Fidelis Care is directly addressing the deficiencies noted in the review and strengthening oversight to ensure sustained compliance for DCP&P members going forward.	
MLTSS – 2024 HCBS Care Management Review	No opportunities for improvement were noted for this review period.	N/A
FC/WCHP should address all deficiencies noted in the MLTSS – NF/SCNF 2024 CM Review for elements that scored below 86%.	Fidelis Care is committed to addressing all deficiencies identified in the 2024 MLTSS–NF/SCNF Care Management review for any elements scoring below 86%. To drive sustained improvement, Fidelis Care leverages multiple performance monitoring tools, including Care Management Scorecards, one-on-one meetings, monthly Shared Services audits, and weekly case note reviews. These tools provide timely, targeted feedback at both the individual and team levels. In addition, Fidelis Care has implemented corrective action plans for any identified gaps, with clear accountability for care managers and supervisors. Progress is tracked through ongoing monitoring and escalation protocols to ensure deficiencies are resolved promptly and performance consistently meets or exceeds compliance standards. For Ongoing Care Management, Fidelis Care MLTSS Care Managers were requested to ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.	Addressed

[1] **Addressed**: Managed Care Organization (MCO)'s Quality Improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2025. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

HNJH Response to Previous EQR Recommendations

Table 61 displays HNJH's progress related to the *State of New Jersey DMAHS, Horizon New Jersey Health Annual External Quality Review Technical Report FINAL REPORT: April 2025,* as well as IPRO's assessment of HNJH's response.

Table 61: HNJH Response to Previous EQR Recommendations

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
HNJH should continue to focus its efforts on provider recruitment in order to improve	Horizon continues to assess the pediatric subspecialty network. At the end of 2024, Horizon completed negotiations with Children's Hospital of Philadelphia ("CHOP") to add facility locations, and approximately	Remains an opportunity for improvement

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
access to care for Pediatric Specialists Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Salem, Sussex, Union and Warren counties.	2,000 employed practitioners to the network. Recruitment efforts continue in 2025 with an emphasis on targeting such specialties as Pediatric Allergy & Immunology, Hematology & Oncology, Sleep Medicine and Psychiatry as well as continuing to assess the network as a whole.	
HNJH should continue to expand Dental network in Hunterdon, Ocean and Warren counties.	Horizon Dental Operations partnered with SKYGEN USA, the delegated dental vendor, to identify prospective providers, as well as acceptable fee schedule parameters for negotiation. Horizon continued the following interventions in collaboration with SKYGEN: The deficiency noted for Ocean County was closed by 3Q 2024 at 97.10% As of 4Q 2024 access has increased for Hunterdon -76.70 (+2% increase) and Warren-77.90% (+1.2% increase) counties. Horizon continued the following interventions in collaboration with SKYGEN: 1. Reach out to large provider groups to see if they are willing to add additional providers. 2. Review “4 Plus County” network roster to confirm if any providers can be moved to the main, counted network, or if any providers can switch primary status with another county that is currently meeting dental network requirements. (This is in regard to current workflow for three county rule to ensure providers are providing at least 20 hours a week in each office). 3. Identify additional providers that may fill the gap. 4. Utilize zip code demographics to assist with closing the gap. 5. Utilize New Jersey’s Yellow Pages to search for offices in zip codes that are deficient. 6. Follow up weekly with offices that are in fee negotiations. 7. Do weekly follow-up with each office for a maximum of (7) outreach attempts for offices not responding. 8. Dental Director outreaches to interested providers to have direct discussions about joining the network.	Remains an opportunity for improvement

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	9. Review out of network claim utilization reports for prospective providers. 10. Review of SKYGEN's monthly recruitment and contracting reports to ensure providers in deficient counties are credentialed timely. 11. New Intervention: Collaborate with the Commercial line of business to recruit providers for the HNJH network.	
HNJH should focus on improving appointment availability for adult PCPs, Specialists, OB/GYNs, and Behavioral Health providers, as well as improve PCP after-hours availability.	Providers who fail annual appointment availability and after-hours studies will be asked to create a Corrective Action Plan (CAP) to ensure compliance moving forward. In addition, those that submit the CAP will be re-audited for quality purposes. Providers that fail the re-audit may be subject to an administrative sanction for failure to comply with the Managed Care Contract. Telephonic educational outreach is made to providers who failed the re-audit for 24 Hour Access by the Provider Experience team, as well as those who fail the re-audit for Appointment Availability. Articles are posted on online and in the Provider Pulse newsletter to educate practitioners on the Access Standards, as well as to provide the overall results from 2024. This will include information on the status, and a link to the Physician Manual, which contains the standards. A fax blast was sent out in Q2, 2025 to all PCP Medicaid practitioners with a reminder about the 24-Hour Access Standards, and link to the Physician Manual. An additional news article was posted in Q2, 2025 with information specific to the use of answering machines for 24 Hour Access. **Behavioral Health**: Letters were mailed to BH providers who failed the appointment availability standards requesting they submit a corrective action plan. Educational articles highlighting the access standards and overall audit results were shared through our online newsletter (Provider Pulse). Key information on Access Standards and audit findings were also distributed via our important reminder email blast in Q1, 2025. Additionally, BH provider orientations and BH	Remains an opportunity for improvement

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	biannual webinars cover appointment availability expectations.	
HNJH should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.	The Provider Directory is maintained on the Horizon website and updated nightly through an automated feed from the Provider Network Operations (PNO) application. The PNO application is the source system utilized to store and maintain provider data. Providers can submit requests for their data to be updated in the Doctor/Hospital Finder in one of four ways: 1. Online Provider Maintenance Tool: This is an automated tool that allows providers to update their data directly into PNO. These requests are processed in real-time and automatically updated to the DHF on a nightly basis. 2. Horizon Data Submission Template: This is a form that is completed by the provider and emailed to a secure email box- Autosubmission_@Horizonblue.com. These forms are processed systemically by a bot, unless an error occurs that requires manual resolution by the Provider Data Management team. 3. CAQH: This is a national database that the provider and Horizon subscribe to that centralizes provider information. The provider can update their demographic information and attest that their information is complete and accurate. The automated CAQH feed is sent to Horizon on a nightly basis where an automated reconciliation is performed between PNO and CAQH. 4. NCompass: Providers can submit data update requests via phone, mail/correspondences, fax, or email. Tickets for these requests are created in NCompass by Customer Service agents and are routed to the PDM team for processing. Horizon's Physician Data Management (PDM) team conducts routine assessments and validation of the provider directory in the following ways. 1. Horizon sends quarterly email communications to the network to encourage validation and attestation of demographic data. The communication provides detail on the methods to update and to attest to their data. The Provider Data Management team has a weekly process to run a report identifying providers who have not attested to their data. Providers who	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	fail to attest are assigned for telephonic outreach and validation. 2. Horizon has partnered with HiLabs, a data validation company to provide data validation and outreach services. Horizon receives monthly reports from HiLabs and takes the necessary action based a pre-defined data confidence algorithm. Actions include attestations for information verified as accurate or phone outreach by HiLabs and Horizon for information requiring confirmation. 3. The PDM team conducts monthly provider data audits which measure the accuracy of the online provider directory in accordance with CMS methodology. This audit samples providers from the CMS required specialties including Behavioral Health and other provider specialties as determined by business priorities. This audit reviews the data received through all channels, including but not limited to CAQH, Telephone Outreach, HiLabs, and Self-Service Tools. 4. Horizon performs monthly audits on random data samples pulled by the Blue Cross Blue Shield Association. The Provider Data Accuracy Audit measures the quality, accuracy and outreach compliance for Horizon's data.	
HNJH should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.	Horizon's Credentialing and Recredentialing Policy for Participating Physicians and Healthcare Professionals indicates that board certification for MDs and DOs is verified at the time of credentialing and recredentialing. ABMS and/or AOA is queried to determine if the practitioner is board certified and the effective dates of certification. This information is populated into Horizon's data source system, PNO (Provider Network Operations application). Practitioners who are board certified are displayed in Horizon's Directory Hospital Finder (DHF) with the value of "Yes" in the Board Certified Attribute. The information is verified again when the practitioner applies for re-credentialing.	Addressed
HNJH should ensure its provider network includes providers with disability accommodations. This will enable members	Horizon requires the completion of an Americans with Disabilities Act Provider Survey for each office location at which a Horizon NJ Health provider practices ensuring our understanding of how well the participating location complies with Americans with Disabilities Act (ADA) requirements. This survey is required during initial	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.	enrollment as well as for maintenance request for new practice locations. ADA information is displayed under office information on our online directory. Horizon's credentialing checklist also includes a Special Needs Training/Experience Survey for completion. This form is for medical and behavioral health practitioners to supply information on the level of training/experience they have with treating patients with special needs. This information helps us in making clinically appropriate referrals for our members. The form collects data on patient age, experience and training with physical, mental, substance use, and developmental disabilities. The survey also includes sections for reporting practitioner experience and training with Blind, Deaf, Non-Ambulatory, HIV/AIDS, and elderly patients.	
The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	HEDIS measure performance is monitored on an ongoing basis to improve health outcomes for our members. Interventions are planned and launched for both members and providers to help improve HEDIS measure performance and close member care gaps. An impact analysis on interventions is completed to measure effectiveness of existing Interventions and new Interventions are developed based on barrier analysis. HEDIS measure performance is reviewed during the HEDIS workgroup meetings with a report out to the Quality Improvement Committee on a quarterly basis. In 2025, several new and continuing initiatives are underway to improve performance for measures that fell below 50th percentile, and to maintain performance of those measures performing at or above 50th percentile. The initiatives include: • Ongoing Member education using various modalities – Mailers, text campaigns, IVR calls and member newsletters educating members on the importance of needed screenings such as annual well visit, preventive screenings, immunizations and managing chronic conditions such as Diabetes. • Targeted Live outreach: ✓ Prenatal/Postpartum care (Target members - African American with lower compliance rates). ✓ Well-child visits to parent/guardians with children that have care gaps.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Member Rewards program 2025: ✓ Early launch of Parent/Baby member rewards program where members can earn incentives for completing a Prenatal and Postpartum visit each; incentives for well-child visits (up to 6 visits) and for lead screenings. ✓ Continuation of Diabetes A1C testing and Eye exam measure rewards program. • Expansion of texting campaigns targeted at measures such as Lead Screening, Immunization, Prenatal - postpartum care. • Launch of IVR call campaigns targeting several preventive screening measure and chronic condition such as Diabetes. • Email and social media campaigns targeting well child visit/Lead screening and CIS measures. • Implemented partnership with providers for mobile mammography screenings to close care gaps. • Results & Recognition Program: In the Results and Recognition (R&R) Program, each participating provider is paired with a Clinical Quality Improvement Liaison (CQIL), who meets with them regularly based on their availability. These meetings focus on reviewing gap reports, identifying barriers and developing strategies to improve performance. The program also offers quarterly live webinars on key measures. Through the Quality Resource Center (QRC), providers can access billing tips, HEDIS guidelines, the Provider manual and recorded webinars for on-demand learning. • Behavioral Health: Several BH initiatives are in place to impact HEDIS measure performance including: ✓ Quarterly virtual and/or in person provider education sessions reviewing behavioral health HEDIS measures, clinical best practices, available resources and member specific data. ✓ Monthly touchpoints with assigned provider groups and new providers identified/outreached for ongoing engagement by BH HEDIS Team.	

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	✓ Provider Webinars focused on improving patient outcomes (offered live and on demand). ✓ Member and provider newsletters distributed throughout the year focusing on BH HEDIS performance and improving treatment outcomes. ✓ Member outreach letters mailed to encourage treatment compliance. ✓ Additional provider support resources developed including an online metabolic wellness page and provider and member facing flyers that encourage care coordination and adherence to treatment recommendations. ✓ Participation in various community outreach events and partnership with Case Management to share data and outreach members in need of required follow-up care specific to the ADD-E measure.	
The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that perform below the 50th percentile.	Horizon remains committed to improving CAHPS survey results in 2025. We've developed an annual workplan for measures that fall below the 50th percentile for adults, children, and children with chronic conditions. We have implemented initiatives focused on enhancing member experience and satisfaction and promoting overall health. The Quality Management team is working closely with various departments including Case Management, Member Experience, Network, Health Equity, Community Outreach and Member Services to address all CAHPS measures prioritizing those that need improvement. Horizon continues to assess the pediatric subspecialty network. At the end of 2024, Horizon completed negotiations with Children's Hospital of Philadelphia ("CHOP") to add facility locations and approximately 2,000 employed practitioners to the network. The contract effective date was 10/1/2024 and providers have been added to the network upon completing credentialing in Q1 and Q2, 2025. We also made significant progress in closing pediatric specialty gaps 1st and 2nd quarter of 2025. We have been able to close all 21 gaps in Pediatric Dermatology, Adolescent Medicine and Child Development gaps. Continued recruitment efforts into 2025 will target such specialties as pediatric allergy and immunology, hematology/oncology, sleep medicine and psychiatry.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	To enhance providers CAHPS understanding and performance in 2025, CAHPS related education and support has been integrated into monthly meetings, webinars, email blasts and provider newsletters. Some of the topics included are CAHPS Fast Facts, Focus on Care Coordination, Benefits of Effective Communication, AWV vs Physical, Getting Needed Care, Behavioral Health Resources, Rating of Healthcare with emphasis on Access to care, Availability and the Importance of the Provider Patient Relationship, Appointment Availability Standards, 2024 appointment availability survey results, and Getting the Right Care at the Right Place. In the first quarter of 2025, Horizon implemented monthly meetings to expand engagement with value-based provider partners that support Medicaid members. Currently, 19 partners are participating, including those that serve pediatric populations. These sessions aim to deliver member-level education and monthly reports are distributed to partners. This collaboration impacts approximately 340,000 members. Horizon strives to engage members by providing educational content through various communication methods, including mail, email, text, a member newsletter and the Horizon NJ Health website. Multiple channels were used to educate on the importance of well visits and vaccinations for adults, children, and adolescents with information to support finding a provider though the online directory or member services if a provider is needed. A sample of Newsletter articles in 2025 includes: Appointment availability, Is Care Management Right for You, Five Ways to Prevent Falls, What to Know about Health Equity, Help is Available in the Community, Get the Right Care at the Right Place, Taking Medications as Prescribed, Early Intervention, and Need a Ride to Your Appointment?	
HNJH should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • GP: Identification, Outreach, and all CM element specific	HNJH addressed the GP: Identification, Outreach, and CM Element specific deficiencies noted, through the following Corrective Action Plan (CAP) activities: • In June of 2024, Horizon enhanced a visualization tool for monitoring individual care manager compliance, this includes Comprehensive Need Assessments (CNAs), initial care plan development, and ongoing care plan updates.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the review.	• Daily compliance monitoring via Tableau Dashboards for supervisors, who are remediating CM when non-compliance is observed. • Instituted performance management with monthly chart audits (minimum of 2 per care manager). • Completion of inter-rater reliability reviews using audit tools to ensure consistency and accuracy. • Launched comprehensive CM training sessions covering regulatory compliance, care planning, coordination and care management roles. • Further improved initial outreach and enrollment workflow to include aggressive outreach to members in acute inpatient settings.	
HNJH should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DDD: Preventive Services, Coordination of Services, and all CM element specific deficiencies noted in the review.	HNJH addressed the Preventive Services, Coordination of Services and all CM Element specific deficiencies noted in the DDD Population Review, through the following CAP activities: • The Care Management Initial Outreach and Enrollment workflow was enhanced to include an aggressive outreach process for members in an acute inpatient setting at the time of identification. • Care management workflows were revised to ensure completion of CNA's, care plan development, and ongoing plan updates for all ID/DDD members. In events of unresponsiveness, completion/implementation is based on utilization review and collateral data. • Added 14 dedicated DDD Care Managers and 1 Supervisor since July 2024, resulting in reduced overall caseloads and increased capacity for timely preventive and coordination services. • Appointed a Case and Case Management Director to provide oversight, drive compliance, and ensure accountability across all CM elements identified as deficient. • Enhanced aggressive outreach protocols including the DDD_DCPP inaccessible- Lost to contact workflow which has been revised. This includes the care manager escalating interventions and referrals to Community- Based Care Management when members are unresponsive. • Launched comprehensive Care Management training sessions covering regulatory compliance, care planning, coordination and care management roles.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
HNJH should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DCP&P: All CM element specific deficiencies noted in the review.	HNJH addressed all Care Management element specific deficiencies noted in the DCP&P review, through the following CAP activities: • Care management workflows were revised to ensure completion of CNA's, care plan development, and ongoing plan updates for all DCP&P members. In the event of unresponsiveness, completion/implementation is based on utilization review and collateral data. • Appointed a Case Management Director to provide oversight, drive compliance, and ensure accountability across all CM elements identified as deficient. • Enhanced aggressive outreach protocols including the DDD_DCPP inaccessible- Lost to contact workflow which has been revised, this includes Care Management escalating interventions and referrals to Community- Based Care Management when members are unresponsive. • Launched comprehensive Care Management training sessions covering regulatory compliance, care planning, coordination and care management roles. • Enhanced a tool for monitoring individual care manager compliance, this includes CNA's, initial care plan development, and ongoing care plan updates. • Implemented daily compliance monitoring via Tableau Dashboards for supervisors who are remediating CM when non-compliance is observed.	Addressed
HNJH should address all deficiencies noted in the MLTSS – HCBS 2024 CM Review for elements within groups that scored below 86%.	Horizon submitted its MLTSS – 2024 HCBS CM Audit Corrective Action Plan (CAP) in March 2025, and it was subsequently approved. Horizon continues to monitor these areas identified as opportunities for improvement by IPRO (scoring below 86%) and requested by the State: • HNJH should ensure that Initial Outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment; • HNJH should ensure that review of Member's placement and services occurs timely (an ongoing face-	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit); and • For Members discharged to their own home, HNJH should ensure that in home services are in place in a timely manner. Additionally, DMAHS requested that corrective action in the Ongoing Care Management Category also include the following specific focus Element cited in Groups C and D – For Members who were discharged to an HCBS setting, the Care Manager's onsite review should occur within ten (10) days of discharge. CAP activities included: MLTSS CM staff re-education occurred through Operational Workflow updates and at MLTSS CM staff meetings; new data fields were added into the MLTSS CM Tableau Dashboard for monitoring purposes; and enhancements were made to the MLTSS Daily Hospital Discharge reporting used by MLTSS CM staff.	
HNJH should address all deficiencies noted in the MLTSS – NF/SCNF 2024 CM Review for elements that scored below 86%.	Horizon submitted its MLTSS - 2024 NF/SCNF CM Audit Corrective Action Plan (CAP) in April 2025, and it was subsequently approved. Horizon continues to monitor these areas identified as opportunities for improvement by IPRO (scoring below 86%) and requested by the State: • HNJH MLTSS Care Managers should ensure the Member's record contains copies of Facility Care Plans during the review period. • HNJH MLTSS Care Managers should ensure the Care Manager participates in a minimum of one Interdisciplinary Team (IDT) meeting per year. • HNJH MLTSS Care Managers should ensure the Member's Plan of Care is amended when a Member experiences a significant change in condition. This includes Performance Measure (PM) #9a - Member's Plan of Care is amended based on change of Member condition. CAP activities included: MLTSS CM staff re-education occurred at a series of HNJH MLTSS NF/SCNF Care	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Management Workgroup meetings; the HNJH Medicaid Quality Improvement Unit re-reviewed the charts that were auditing for inclusion of Facility Care Plans and discussed revisiting and enhancing Annotating and Bookmarking strategies for future Annual NF/SCNF Chart Audits; the HNJH Provider Alert Forms were updated, re-posted to the HNJH Provider website, and then subsequently Fax-blasted to MLTSS providers by the HNJH Provider Contracting Team; and instructional guidance to improve provider communication and care coordination with MLTSS care management, and encourage timely notice of member events such as facility discharge planning was added into the Provider Pulse Newsletter.	

[1] **Addressed**: Managed Care Organization (MCO)'s Quality Improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2026. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

UHCCP Response to Previous EQR Recommendations

Table 62 displays UHCCP's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Community Plan of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2025,* as well as IPRO's assessment of UHCCP's response.

Table 62: UHCCP Response to Previous EQR Recommendations

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address the Core Medicaid PIP validation elements that were determined to be not met or partially met.	The reviewer of the EPSDT PIP that scored 82.5% found that the barrier analysis findings were not used to modify interventions. UHCCP NJ re-reviewed the data and found that one office did not send out a schedule list (intervention) timely for two months during an unexpected management shift. Overall the combined practices submitted 103 of 105 (98.10%) combined months of schedule lists for intervention timely. The Health Plan considers this occurrence to be within acceptable parameters and did not indicate a need for process modification or change to intervention. Additional reviewer comments were UHCCP NJ might want to consider how enrollees could be referred by the MCO to immunization appointments at other sites, such as public health departments; however, the performance Indicator focus is to increase the well visits so the providers can administer the vaccines at the well visit. The aim of the project is to increase well visits and immunizations in the target age group. Referring members to the Health Department overrides the importance of the well visit,	Remains an opportunity for improvement

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	disrupts continuity of care, and interferes in the relationship with their providers. Lastly, the reviewer commented that performance indicators did not show any improvement. UHCCP NJ acknowledges despite all of the effort and interventions successfully executed, the plan did not meet the majority of Performance Indicator goals, but six indicators demonstrated year-over-year growth reflecting the positive impact of ongoing efforts in targeted interventions.	
UHCCP should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in multiple Counties.	UHCCPNJ continues to focus efforts on remediation of network deficiencies for all specialties. Network Operations works with various departments to research possible recruitment options and report the status of the findings in three categories 1) research options 2) outreach made, and 3) no providers available. 'Research options' indicates that possible recruitment options are still being researched. 'Outreach made' indicates that providers for possible recruitment have been identified and outreach for contracting has been made. And 'no providers available' indicates that there are no providers to possibly reach out to for contracting because they do not exist in the area. Our goal with indicating these categories is to seek clarity as to whether gap remediation is possible or not. A high-level summary of gap remediation efforts is presented at the quarterly provider advisory committee (PAC). The network operations team also meets twice a month with the contracting team to work collaboratively on contracting and negotiation efforts. In the case of pediatric specialty deficiencies, UHCCPNJ also submits quarterly S3000 reporting and outreach effort updates to DMAHS.	Remains an opportunity for improvement
UHCCP should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Burlington, Hunterdon, Salem, Sussex and Warren Counties.	UHCCPNJ continues to focus efforts on remediation of network deficiencies for all specialties. Network Operations works with various departments to research possible recruitment options and report the status of the findings in three categories 1) research options 2) outreach made, and 3) no providers available. 'Research options' indicates that possible recruitment options are still being researched. 'Outreach made' indicates that providers for possible recruitment have been identified and outreach for contracting has been made. And 'no providers available' indicates that there are no providers to possibly reach out to for contracting because they do not exist in the area.	Remains an opportunity for improvement

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Our goal with indicating these categories is to seek clarity as to whether gap remediation is possible or not. A high-level summary of gap remediation efforts is presented at the quarterly provider advisory committee (PAC). The network operations team also meets twice a month with the contracting team to work collaboratively on contracting and negotiation efforts. UHC Dental has made outreach to providers for contracting for Burlington and Warren counties. Hunterdon county is still being researched by UHC Dental as to whether providers exist for outreach.	
UHCCP should continue to expand the MLTSS network to include at least two providers in every County for Adult Medical Day Care in Hunterdon and Sussex Counties, and Assisted Living in Atlantic, Bergen, Camden, Essex, Gloucester, Hudson, Morris, Passaic, Somerset and Union Counties.	As of July 2025 network deficiency reporting, there is no longer a network deficiency for Adult Medical Day Care in Hunterdon county. After continuing research for recruitment prospects, it has been determined by our MLTSS network contracting team that there are no providers to target that exist within the area per the State's website and other external resources to remediate Adult Medical Day Care in Sussex County. For Assisted Living, our MLTSS network team has contacted all available providers listed on the State's website, as well as additional providers we have identified, to initiate contracting discussions. We continue to monitor the State's website and other external resources to identify and target additional Assisted Living providers for outreach.	Remains an opportunity for improvement
UHCCP should focus on improving appointment availability for OB-GYNs, High Volume Specialists and Behavioral Health providers, as well as PCP after-hours and wait time non-compliance.	UHCCPNJ continues to address appointment availability deficiencies by reaching out to providers who do not meet the required scheduling standards. An initial letter is sent to educate the provider on the standards, followed by a re-survey and up to two additional educational reminder letters reinforcing the appointment availability requirements. If a provider still does not meet the standard after the third letter, they are contacted directly to determine the reason. When appropriate, their listing may be suppressed from the online provider directory or, in the case of primary care providers (PCPs), their patient panel may be closed. UHCCPNJ also continues to work with providers who have been identified as deficient in after-hours access. These providers will continue to receive up to 3 letters after each 3 survey/re-survey calls from our third-party vendor, which	Remains an opportunity for improvement

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	educates the provider on the appointment availability standards set forth by DMAHS. Providers who are unable to meet the standard after the 3rd letter are contacted to determine the reason for not being able to meet the standard, and if necessary, suppress their entry from the online provider directory, or close their panel (if a PCP).	
UHCCP should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.	UHC offers multiple intake channels to enable practitioners to update, attest to, or validate their demographic information on file. • My Practice Profile (MPP) – a cloud-based digital platform released in 2016, allows individual practitioners and select groups the opportunity to review, update and attest (validate) to their practice demographic information for accuracy. Reminder emails are sent both pre- and post- verification due dates. • Roster Processing – processing tools that are leveraged to standardize rosters and run comparative analytics from source to internal systems. Updates are completed via automation and manual processes for groups who manage their demographics via full annual roster submissions, monthly add/term/change files, and quarterly attestations. Our assigned managers to providers with rosters frequently engage with groups on a daily, weekly, or monthly basis and our Delegated Roster Oversight team works to ensure timely updates are received from delegates for changes to their demographic information. • MPP Roster Upload – as of Q4 2024, groups are now able to submit a roster list of providers through My Practice Profile as an option for bulk notification of changes (10 providers or more) and to verify and make updates for the accuracy of their demographic information on file. Reminder emails are sent both pre- and post- verification due dates. • CAQH Provider Data Portal (PDP) – a partnership with CAQH that leverages their industry wide web-based provider utility for the ingestion of both individual practitioner (Provider Data Portal, Directory) and group (Provider Data Portal for Groups) data (formerly known as Direct Assure and	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Proview for Groups, respectively). PDP is an industry wide source for provider demographic data – all health plans that have rostered the provider for demographic data receive the updated attestation data. Reminder emails are sent both pre- and post-verification due dates. UHC exchanges our internal demographic data to CAQH monthly, and variances are reviewed by providers with corresponding response files transmitted daily. Element corrections are made as applicable. • Inbound Demographic Changes – providers have the ability to use a "Chat" feature for requested demographic changes when engaging with the provider call center. • Provider Verification Outreach (PVO) – Leveraged for providers who have not updated, attested or who have had a business rule trigger a demographic verification request. Verifications may be initiated by an email process leveraging Adobe Acrobat Sign web form capabilities or telephonically via outbound call. PVO makes up to three (3) attempts for a successful verification to occur. Practitioners may be contacted directly via phone or email to confirm or update their demographic data. If the data cannot be verified the UHC High Risk Suppression Programs includes a robust review to identify provider addresses without either an attestation or claim on file at a listed location. If a provider does not update and verify their data or does not have three (3) or more claims on file for a listed address, there is a high probability that the address is no longer an active service location for the provider. If identified as either no attestation or a claim being on file, UHC will then suppress the provider address from the directory until the provider updates and/or attests to their data. Through separate attestation processes, upon receipt of an attestation, UHC will restore the provider in the directory display. UHC also conducts random monthly spot checks to validate provider practice information. Additionally, we have an internal process where externally facing team members can report demographic	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	discrepancies, and a member of the operations team will review, validate and work on resolving the issue to have the provider's information updated, or removed from the directory, as appropriate. This allows the health plan to prioritize the providers who are being outreached to by our team members.	
UHCCP should ensure the online provider directory accurately lists all board-certified providers and routinely conduct reviews and verification processes to maintain the accuracy of this information.	All providers are included in the directories after completing the credentialing/contracting process. Provider credentials are primary sourced verified to ensure appropriate licensure. UnitedHealthcare (UHC) utilizes multiple methods to ensure provider data accuracy. These methods include reoccurring auditing and monitoring processes to ensure our provider directories display the most up-to-date provider information possible, as the provider's data changes often. Specifically for our provider directories, we currently conduct ongoing quality reviews through provider data attestations, phone call campaigns to providers, and other methods. An attestation (verification) is confirmation from a provider as to the accuracy of the provider's data that will be displayed in our directories, at which time an opportunity for updates can be made if needed. Directories are completely processed on a quarterly basis and are maintained twice per month to ensure the accuracy of the information; The data sources are monitored daily post deployment to again maintain accuracy.	Addressed
UHCCP should regularly review the accessibility options listed under providers' profiles to ensure their accuracy.	Providers' accessibility is attested to by the provider during the initial credentialing cycle and then again during the recredentialing cycle. In the event of a quality of care or quality of service concern, we would perform a direct office visit. Additionally, physical accessibility to the building, exam rooms, and bathrooms including accommodations for the handicapped is reviewed if a complaint is received regarding accessibility.	Remains an opportunity for improvement
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions	UHCCP NJ completed a barrier analysis on the low performing measures and utilized findings to develop interventions aimed at rate improvement. The overall strategy included linking members to available resources including Flu Finder function on the member website, promoting virtual visits, and writing member-facing newsletter articles on related health topics. Member educational materials for dental care, pregnancy care, preventive health and chronic disease management were	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	distributed at health fairs. The plan created provider specific member level detailed reporting of open care gaps including final dates of service for measure compliance. Providers were also made aware of educational sessions available via webcasts and on demand presentations, and their staff informed about best practices including NJIIS registry, PRA completion, and EMR settings. UHCCP NJ will continue to monitor measure rates monthly and review findings with key plan stakeholders including Behavioral Health, Pharmacy, Care Management and Medical and Dental providers.	
The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile	The CAHPS workplan, developed by the CAHPS taskforce, focused on the elements that performed below the 50th percentile. Key stakeholders from multiple teams e.g., Member Call Center, Quality, Provider Relations, and Care Management participated in the development of the interventions. The intervention activities focused on both members and providers. Handouts for members and providers were developed and distributed, articles were placed in the member newsletter, and member-facing staff training sessions were held. The Workplan is monitored on a regular basis and reported quarterly to the Quality Management Committee.	Addressed
UHCCP should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • GP: Identification, and all CM element specific deficiencies noted in the review.	UHCCP has conducted a gap analysis based on audited sample charts to review specific cases and identify consistent patterns or contributing factors that may be causing delays in the timely completion of IHS for new enrollees. For new enrollees, UHCCP has enhanced tracking system and reporting to identify members requiring IHS, ensuring they are effectively monitored from the point of enrollment through the 45-day completion deadline. In addition, UHCCP has partnered with IT to further strengthen tracking and monitoring systems, providing comprehensive oversight from enrollment through completion of the Comprehensive Needs Assessment. UHCCP also implements targeted, sample-focused audits of the population to ensure compliance. We have addressed the risk level finding with bi-weekly reports identifying individuals with no risk level. This process is also part of a new Care Management checklist and was reinforced through team re-education. With these measures in place, we have been showing 100% compliance, validated by audit samples of the risk level implementation.	Addressed
UHCCP should address the	In response to the deficiencies identified in the 2024 Care Management Audit for the DDD population, UHCCP has	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DDD: All CM element specific deficiencies noted in the review.	implemented a comprehensive improvement plan including the following actions: 1. **Enhanced Tracking and Monitoring**: UHCCP partnered with IT to improve tracking systems for new enrollees, ensuring timely completion of the Comprehensive Needs Assessment (CNA) within the 45-day requirement. In addition, reporting is utilized to identify enrollees requiring the level of care management documented. 2. **Enhanced Job Aids and Standardized Documentation Tools**: Introduced enhanced job aids, including preventive checklists and documentation templates, to support Care Managers in consistently addressing required elements such as dental needs and ensure efforts are appropriately documented. 3. **Root Cause Analysis and Education**: Conducted gap analyses and sample audits to identify documentation and process gaps. Findings informed refresher trainings that provided clear guidance and reinforced the use of standardized tools. 4. **Ongoing Monitoring and Feedback**: Extensive and ongoing audits implemented of enrollee charts to assess CNA timeliness, dental needs addressed/discussed and to identify deviations. Timely feedback is provided to ensure prompt corrective actions and sustained improvement. These actions reflect UHCCP's commitment to continuous improvement and compliance with contractual obligations. All interventions are actively monitored to ensure sustained performance and quality of care for the DDD population.	
UHCCP should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DCP&P: All CM element specific deficiencies noted in the review.	There were no findings specific to DCP&P in the Core Medicaid – 2024 CM Review.	N/A

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2024 CM Review for elements within groups that scored below 86%.	Member Outreach Recommendation: Group C & Group D: UHCCP should ensure that initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions. 3. Daily monitoring by managers and analyst will trend data monthly for compliant initial outreach using enhanced report 4/1/2025. Ongoing Care Management Recommendation: Group C, Group D, & Group E: UHCCP should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	management huddles starting April 2025 with ongoing discussion for interventions. 3. Weekly monitoring Recommendation: Group D: UHCCP should ensure that Member files that indicate a change from the Initial Plan of Care have documentation that the Member's Plan of Care is updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signed and is provided with a copy of the Plan of Care. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions. 3. Daily monitoring Recommendation: Group C, Group D, & Group E: For Members who were discharged to a HCBS setting, UHCCP should ensure the onsite review occurs within ten (10) days of discharge. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	management huddles starting April 2025 with ongoing discussion for interventions. 3. Daily and monthly monitoring Recommendation: Group C, Group D, & Group E: For Members who were discharged his/her own home, UHCCP should ensure that in home services are in place in a timely manner. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions. 3. Daily and monthly monitoring. Recommendation: Group D & Group E: UHCCP should ensure that Member files indicate a significant change in Member condition have documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Daily Monitoring Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) Recommendation: Group C & Group D: United Healthcare should ensure that the Member is assessed for PCA services within 45 days of enrollment into MLTSS. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions. Performance Measure #8- Plans of Care established within 45 days of MLTSS enrollment Recommendation: Group C and Group D: UHCCP should ensure that the Initial Plan of Care is completed, signed, and mailed within 45 days of MLTSS enrollment. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Daily monitoring by managers and analyst will trend data monthly for compliant initial plan of care using enhanced report 4/1/2025. Performance Measure #9- Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination was missed for Group E Recommendation: Group E: UHCCP should ensure that the Plan of Care reassessment for MLTSS Members is conducted within 30 days of annual LOC re-determination. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS management huddles starting April 2025 with ongoing discussion for interventions. 3. Weekly monitoring Performance Measure #9a- Plan of Care for MLTSS Members amended based on change of Member condition was missed for Group D and Group E **Recommendation:** Group D and Group E: For MLTSS Members with a change in condition, UHCCP should ensure that the Plan of Care is amended to reflect the changes in Member condition. Response: 1. MLTSS managers to complete re-training with all MLTSS CM staff and obtain signed attestations to confirm receipt of training by 3/28/2025. 2. Managers will be able to view charts audited for their team monthly and will document staff remediation in SharePoint audit tool. Monthly monitoring of team performance using new tool will be reviewed during MLTSS	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	management huddles starting April 2025 with ongoing discussion for interventions. 3. Daily monitoring	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2024 CM Review for elements that scored below 86%.	**Facility and MCO Plan of Care- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period.** **Recommendation:** UHCCP MLTSS Care Managers should ensure the Member's Care Management record contains copies of any Facility Plans of Care on file during the review period. **Response:** 1. MLTSS Managers will utilize the audit share point to monitor Facility Plan of Care is being obtained by the MLTSS CM. 2. MLTSS Managers to complete re-training with all MLTSS CM staff and obtain attestations by 4/11/2025. 3. Managers will review audits for their team on a monthly basis and will document staff remediation in the Share Point Audit Tool. 4. MLTSS Audit Team will notify CM and Manager of missing Facility Plan of Care. **Ongoing Care Management** **Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period.** **Recommendation: UHCCP MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.** 1. Managers will utilize NJ IDT Report to monitor compliance. 2. Annual training for MLTSS CM Nursing Facility face to face visit process completed 4/11/2025. This training included NF IDT requirements for chart documentation to capture annual IDT requirement for each Nursing Facility member. Attestations were collected from each MLTSS CM.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Manager will track annual NF IDT using weekly activity reporting. **Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).** **Recommendation:** UHCCP MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members). **Response:** 1. Managers will review the audit Share Point to track MLTSS CM compliance of member visits. 2. Annual training for MLTSS CM NF face to face visit process completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate CMs who require additional retraining. 3. Manager will review F2F visits via POC and activity documentation reporting. Managers will meet with staff who are non-compliant to review reporting and audit scores to create a plan to get membership assigned in compliance. If needed, care management staff will be placed on a corrective action plan with weekly manager meetings to review schedules, work processes, and performance. Care management staff will be re-trained as needed to ensure understanding of contractual requirements. Staff who do not demonstrate improvement with compliance of timely onsite/telephonic review of member may be subject to termination. 4. Managers will meet with MLTSS CMs and review timeliness of the Plan of Care visits. **Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.**	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Recommendation: UHCCP MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member and/or representative. **Response:** 1. Annual training of Plan of Care Review for MLTSS CM completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate staff who require additional training. 2. Managers will review audits, Plan of Care Report, and will meet with CMs regarding missing documentation. **Care Manager educated the Member on how to file a grievance and/or an appeal.** **Recommendation:** UHCCP MLTSS Care Managers should ensure the Member is educated on how to file a grievance and/or an appeal. **Response:** 1. Managers will review audits, complete file reviews and check CM documentation to ensure that members are being educated on how to file a grievance and/or appeal. 2. Annual training of how to file a grievance and/or appeal for MLTSS CM completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate staff who require additional training. **Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.** **Recommendation:** UHCCP MLTSS Care Managers should ensure completion or confirmation of PASRR ll prior to Member transition of NF/SCNF.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Response: 1. Managers will review audits, complete file reviews and check CM documentation to ensure that members have a PASRR II on file prior to the member's transition to the NF/SCNF. 2. Annual training ensuring that members who require a PASRR II have one on file prior transition to NF/SCNF for MLTSS CM completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate staff who require additional training. 3. Managers will monitor completion of the annual PASRR training to ensure compliance. **PM #8. Plans of Care established within 45 days of MLTSS enrollment.** **Recommendation:** UHCCP MLTSS Care Managers should ensure that the Member's Plan of Care is established and a copy provided to the Member within 45 days of MLTSS enrollment. **Response:** 1. Annual training ensuring that MLTSS CMs were educated on the requirements of members having an established Plan of Care within 45 days was completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate staff who require additional training. 2. The MLTSS management team continues to monitor POC completion report weekly and meet with the individual CMs monthly to ensure timely completion with the initial POC within 45 days and ensuring members have a copy. 3. Managers will review the Initial Plan of Care Report with member during supervisory visit to ensure that all new enrollees are being completed within the first 45 days of enrollment. Re-education and assistance with visit prioritization will be provided to CM staff by manager as needed during 1:1 meetings. 4. Managers will review audits, complete file reviews and check CM documentation to ensure that new	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	members have a Plan of Care established within 45 days. 5. Managers will review the clinical audits to ensure a Plan of Care is being established within 45 days for new enrollees. Managers will re-educate CMs who require improvement. Staff who do not demonstrate improvement and compliance are subject to a Corrective Action Plan which could lead to termination. PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. **Recommendation:** UHCCP MLTSS Care Managers should ensure training is provided to MLTSS Members on identifying/reporting Critical Incidents. **Response:** 1. Annual training educating members on how to report a Critical Incident was completed 4/11/2025. Signed Attestations to confirm receipt of training obtained. Managers will continue to re-educate staff who require additional training. 2. Manager monitor compliance of mandatory CI training. CM's who fail to complete the required My Learning timely are subject to receive a written warning. 3. Audit reviews includes metric to confirm instructions for reporting CI to care manager has been documented in the member MLTSS plan of care.	

[1] **Addressed**: Managed Care Organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2026. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

WPNJ Response to Previous EQR Recommendations

Table 63 displays WPNJ's progress related to the *State of New Jersey DMAHS, Wellpoint New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2025,* as well as IPRO's assessment of WPNJ's response.

Table 63: WPNJ Response to Previous EQR Recommendations

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon and Warren Counties.	In Hunterdon County, the majority of physicians are directly employed by Hunterdon Healthcare and its affiliated Independent Practice Association (IPA). Hunterdon Healthcare has requested to enter into a delegated credentialing agreement with Wellpoint. This agreement, alongside the pre-delegation audit, received approval from the Division of Medical Assistance and Health Services (DMAHS) and the Department of Banking and Insurance (DOBI) on June 27, 2024. Wellpoint has successfully integrated Hunterdon providers into its systems. The inclusion of these providers has fully rectified the Adult PCP deficiency within these counties. In addition, Wellpoint is contracted with all available health systems, Atlantic Health System and St. Luke's in Warren county.	Remains an opportunity for improvement
WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Hunterdon, Sussex and Warren Counties.	Wellpoint has agreements with every health system in Hunterdon, Sussex, and Warren Counties. Wellpoint membership in these counties, Hunterdon (450 members), Sussex (961 members) and Warren (591 members), have full access to care among these entities and surrounding geographic footprints. Hunterdon County: Wellpoint has also finalized an agreement with Hunterdon HealthCare, LLC (HHCP), effective August 1, 2023. HHCP has entered a contractual agreement with Wellpoint for its entire health system, which employs the majority of pediatricians in Hunterdon County, a neighboring locality to Warren County. The delegated credentialing relationship with HHCP was approved by DMAHS and DOBI on June 27, 2024. Sussex County: Wellpoint has a provider agreement with the only health system in Sussex County – Atlantic Health System. Warren County: Wellpoint has provider agreements with both Warren County based health systems – Atlantic Health System and St. Luke's Warren Hospital and Physician Group.	Remains an opportunity for improvement
WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in	Wellpoint conducts a quarterly comprehensive study of New Jersey providers to identify recruitment opportunities by geo-location and provider specialty. This analysis entailed review of the entirety of NJ Medicaid Certified Providers (21st century registered) as produced by DMAHS, National Plan & Provider Enumeration System (NPPES) for	Remains an opportunity for improvement

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Cape May, Mercer, Monmouth, Ocean, and Warren counties.	all Medicaid registered providers and nonregistered providers, NJMMIS, and internal claim processing databases. Wellpoint has additionally reviewed the American Board of Pediatrics and NJ Division of Consumer Affairs to determine if additional providers are available for recruitment to fulfil network adequacy requirements. Wellpoint also reviews competitor websites and out-of-network authorizations/claim data to ensure a sufficient network. These waivers are reviewed by the State. Additionally, Wellpoint's Care Management and Provider Solutions departments work together to ensure that members are provided prompt access to non-participating providers as necessary through Single Case Agreements. This includes coordinating transportation when needed.	
WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Burlington, Cape May, Hunterdon, and Warren Counties.	Our focus is on improving access and addressing gaps identified among Dental providers in Burlington, Cape May, Hunterdon, and Warren Counties. To broaden our network, boost utilization and access, we thoroughly examine the directories of competitors and commercial insurance providers. We reach out to in-network dentists seeking their recommendations and potential leads, alongside conducting comprehensive online searches to spot recruitment opportunities. Our outreach prioritizes areas with a shortage of dentists, aiming to enhance member access and utilization. We keep detailed records of our outreach efforts and ensure consistent engagement and follow-ups using emails, phone calls, or face-to-face meetings. We hold monthly, quarterly, and ad hoc meetings to assess provider recruitment and geographic access improvements. To fortify the network, we employ targeted recruitment strategies and offer improved provider reimbursement rates. By leveraging relationships with group practices, we aim to expand in counties lacking access and increase Wellpoint participation. Furthermore, we monitor provider terminations and engage with these providers to prevent them while gaining insights to enhance our network strategies. In cooperation with our dental benefits vendor, we are updating our agreement to provide extra resources for dental providers, thereby strengthening our network and improving access.	Remains an opportunity for improvement
WPNJ should continue to address hospital deficiencies in Salem County.	The audit from the prior year highlighted deficiencies concerning hospitals in Salem County. Wellpoint is now fully contracted with Inspira Health System, situated within the county. Inspira registered for their Medicaid ID number in May 2024, and Wellpoint has accordingly backdated	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Inspira's effective contract date to October 2023. This adjustment is intended to address the identified gap in Salem County.	
WPNJ should focus on improving appointment availability for Adult PCP, OB-GYNs, Other Specialists, and Behavioral Health Providers (Prescribers and Non-Prescribers).	Wellpoint appointment availability compliance most recently (July 2025) has an overall score of 97% compliance. All individual sub-categories are over 90% with the exception of Behavioral Health Prescribers as overall compliance of wave 1 and wave 2 surveys. We fully anticipate this category to continue to rise with our continued interventions. We have increased survey frequency to biannual and have updated key phrasing of the questions posed on the survey to assist in a clearer understanding of the question. Specific to the specialties mentioned, below are the results for Wave 1 & Wave 2 (July 2025): Adult PCP: 98% Other Specialists: 95% Behavioral Health Prescribers: 86% Behavioral Health Non-Prescribers: 93% Wellpoint acknowledges the importance of the appointment availability survey, especially the results concerning specialists who have opportunities for improvement. The survey has been updated from an annual to a biannual schedule. The initial survey checks for compliance, and providers who do not meet the requirements must submit a corrective action plan. The second survey focuses on those providers who were non-compliant in the first survey, giving them a chance to improve. Additionally, Wellpoint's Provider Relations team conducts onsite visits to educate providers.	Remains an opportunity for improvement
WPNJ should ensure that they have evidence of the new enrollee quarterly surveys, as well as the results of these surveys available for review by DMAHS and/or the EQRO	Wellpoint values the informative feedback that member survey responses provide. Wellpoint will continue to refine the way that it tracks, evaluates, and trends this information and maintains it for audit by DMAHS and IPRO.	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
upon request at regularly scheduled site visits.		
WPNJ should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and wrong addresses.	Wellpoint is dedicated to ensuring members have access to accurate provider directories. Wellpoint partners with an enterprise team who monitors the accuracy of our provider directory. The accuracy of the directory is based on provider demographic data alignment and claims activity. In addition, the Wellpoint operations team works with a vendor to conduct provider spot audits. The Wellpoint provider relations team emphasizes the significance of roster reconciliation with all providers to ensure accurate demographic data is submitted to Wellpoint.	Addressed
WPNJ should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.	Wellpoint is dedicated to ensuring members have access to accurate provider directories. Wellpoint works with our internal configuration team to ensure board certification status is a mandatory field within all provider roster submissions. Provider demographic information is routinely monitored to ensure accuracy.	Addressed
WPNJ should conduct reviews and verification processes to ensure the accuracy of providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.	Wellpoint's credentialing and re-credentialing program complies with local, state and federal regulations and accreditation requirements. Providers are required to attest to meeting ADA accessibility requirements through the submission of their current CAQH Provider Application or New Jersey Universal Physician Application at initial credentialing and at re-credentialing. At initial credentialing Providers are required to attest through completion of the Americans with Disabilities Act (ADA) Provider Survey that their office/group practice as well as each service location meets the requirements of ADA. Providers are also required to attest to their experience and qualifications for providing care to the aged, blind, deaf, and disabled, persons with developmental disabilities, mental health/behavioral or substance abuse problems, or with HIV and/or AIDS by completing the Division of Developmental Disabilities and Aged, Blind and Disabled Form. Wellpoint's provider directory has enabled capabilities for members to search for providers who cater to their specific disability accommodations.	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WPNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Wellpoint will continue executing its HEDIS work plan to address measures which fall below the NCQA national 50th percentile. This proactive plan is crucial for identifying care barriers, tracking progress, and guiding interventions throughout the year to enhance quality metrics. In 2023, we focused on underperforming measures over multiple reporting periods by conducting deeper barrier analyses and implementing targeted interventions for both members and providers. Following our legal entity name transition from Amerigroup New Jersey, Inc. to Wellpoint New Jersey, Inc. on January 1, 2024, we observed moderate improvements in performance rates, driven by comprehensive intervention strategies, including modified educational materials for developmental screenings targeting children of all ages. Provider engagement was strengthened with the implementation of the expanded Core Set benchmark report for non-HEDIS Core Set measures, enhancing targeted outreach activities. Educational resources on developmental screenings and the EPSDT toolkit were distributed to providers. We will continue our cross-departmental collaboration, involving teams such as Whole Health, Utilization Management, Care Management, Member Engagement and Outreach, Provider Success, Pharmacy, Behavioral Health, Dental, and EPSDT. By leveraging insights from these teams, we aim to enhance and modify interventions to close care gaps and improve health outcomes. Additionally, we will maintain partnerships with delegated vendors, such as Liberty Dental, to drive improvements in relevant HEDIS measures. Our strategic initiatives include optimizing digital communication channels for faster information dissemination, enhancing provider quality incentives, and refining member incentives and educational materials to boost compliance with preventive services and promote medication adherence. Wellpoint will continuously review data trends and gather feedback from members and providers to refine existing interventions or develop new ones, ensuring consistent	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	improvement in HEDIS performance metrics. We will persist in monitoring these developments on a quarterly basis, using insights to promote continual enhancement across HEDIS measures in upcoming reporting periods.	
The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that perform below the 50th percentile	Wellpoint remains committed to improving Adult, Child, and Child CCC CAHPS scores that fall below the 50th percentile by implementing strategic interventions focused on enhancing satisfaction and health outcomes, driven by and tracked through our established workplan. We have adopted standard business practices that involve partnering with community providers to increase access to care through various outreach events. These initiatives help us connect with members in community settings and promote health education. To expand our service network, we are actively seeking new provider partnerships and continually reviewing agreements to ensure broad access to essential services, thereby improving the overall member experience. Our communication strategies include enhancing telehealth education and maintaining active engagement through digital channels and automated outreach campaigns, making it easier for members to access information and services. Our digital platforms serve as key tools to increase member participation in health programs and initiatives. We regularly conduct surveys to gather valuable member feedback on services, benefits, and cultural needs. This information assists us in refining our strategies and addressing specific areas identified for improvement. Additionally, our Provider Relations and Provider Success teams engage with providers to discuss CAHPS survey results and create awareness about areas where improvements can be made. We also offer enhanced benefits that encourage wellness activities, aiming to motivate members to actively participate in maintaining their health. Through these comprehensive efforts, Wellpoint is dedicated to enhancing member satisfaction and improving CAHPS scores across all categories.	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
WPNJ should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • GP: Identification, and all CM element specific deficiencies noted in the review.	For newly enrolled members of the General Population without an IHS on file, IHS dialer process to be reviewed to ensure proper functionality of dialer and auto-documentation of outreach calls. Initiate random audit of newly enrolled members of the General Population for dialer activity, i.e., outreach calls and letters, to complete an IHS. Review IHS timely completion for members of the General Population and discuss the need for aggressive outreach with CM staff. Educate CM team on identifying newly enrolled members without the appropriate number of IHS outreach attempts on members being touched for assistance, assessments, and/or potential CM. Emphasize and reinforce timely CNA outreach and completion during the next CM Process Improvement Series meeting to be held in October 2024 with all CM teams. NEW: General Population Manager will utilize the NJ Tracker Report specifically to track new enrollees of the general population for timely CNA completion after IHS completion (score ≥5) within 30 days and identification of a member for CM services within 30 days. General Population Manager will review cases without CNAs for evidence of appropriate aggressive outreach and timeliness of completion. Care managers who are non-compliant with this element will be coached and re-educated. General Population Manager to monitor CNA initial outreach and completion rates for newly enrolled members of the General Population. Care managers re-educated and re-trained during team meeting to document preventive services as they verify services are completed during October 2024 team meeting. For the General Population, aggressive outreach attempts and reminders for EPSDT and dental exams for members 0-20 years old in care management added to current spot check audits. Revise EPSDT Reminder Letter to include targeted missing services and education on why it is important.	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Peer-to-peer CM audits for all populations for appropriate preventive services measures. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings. Monitor CM Documentation Report specifically for evidence of documentation related to preventive services. For the General Population: WPNJ should establish an audit process to ensure compliance and accuracy with audit preparation and submissions to the EQRO. Weekly meetings w/ Wellpoint data analyst to ensure accurate information is being pulled for CM/UM reports. Routine quality checks to take place on Wellpoint data analyst's reports.	
WPNJ should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DDD: Coordination of Services, and all CM element specific deficiencies noted in the review.	CM Process Improvement Series meeting conducted with DDD and other CM teams to address internal and external collaboration process and documentation for new and existing members in October 2024. Continue to use the digitized CM audit tool to assist with analysis of CM performance. Peer-to-peer auditing process will continue and reports will be run to identify CMs not meeting requirements. CM Process Improvement Series, a series of monthly educational meetings with the CM teams, will begin in January 2025 with new approaches to educating teams, i.e., videos and reading assignments. Procedures will be reviewed to ensure adequate and appropriate coordination of services for new and existing enrollees, as well as to address other IPRO audit deficiencies. For new and existing DDD members, targeted case reviews of members with challenging coordination of services issues with the team. Utilize additional care managers to assist peers in identifying care coordination services needs for new and existing members to ensure appropriate coordination of services. Emphasize and reinforce timely CNA outreach and completion during the next CM Process Improvement Series meeting to be held in October 2024 with all CM	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	teams. Review process for determining member level of care during October DDD team meeting. NEW: DDD Manager will utilize the DDD DCP&P Case list Report to assess for level of care management documentation and any immediate and follow-up interventions. DDD Manager to audit documentation of member level of care quarterly and ad hoc. DDD care managers re-educated and re-trained during team meetings on how to modify member care plans on exiting enrollees as they verify services are completed and when changes in their condition occurs. "Additional Service Needs" guideline to be added to the DDD care plan and to be added as an internal audit element for all DDD members. Additional Service Needs Guideline added to the CM audit tool. CM Process Improvement Series, a series of monthly educational meetings with the CM teams, will begin in January 2025 with new approaches to educating teams, i.e., videos and reading assignments. Procedures will be reviewed to ensure adequate and appropriate level of care for existing enrollees, and to include the addition of the "Additional Service Needs" guideline for DDD members as well as to address other IPRO audit deficiencies. For the DDD Population, reminders for EPSDT and dental exams added to the current CM audit tool. Revise EPSDT Reminder Letter to include targeted missing services and education on why it is important. Peer-to-peer CM audits for all populations for appropriate preventive services measures. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings. Monitor CM Documentation Report specifically for evidence of documentation related to preventive services. For new and existing DDD enrollees, reinforce communication, collaboration, and documentation of DDD,	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) through October and November 2024 team and round table meetings. CM Process Improvement Series, a series of monthly educational meetings with the CM teams, will begin in January 2025 with new approaches to educating teams, i.e., videos and reading assignments. Procedures will be reviewed to ensure adequate and appropriate contact with state staff, the members' family, PCPs, specialists, and LHD, to include coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services for DDD new and existing enrollees as well as to address other IPRO audit deficiencies. Education to be provided to all DDD staff related to FindHelp Community Resources Link to locate available services. CM auditing process to ensure new and existing DDD members have the required documentation for new and existing members.	
WPNJ should address the deficiencies noted in the Core Medicaid - 2024 CM Review in the following areas: • DCP&P: All CM element specific deficiencies noted in the review.	During DCP&P Team meetings Manager reinforced need and importance of appropriate discharge planning for new enrollees. NEW: DCP&P team to begin using the Stabilization (Post Discharge Management or PDM) process. Manager will utilize the same documentation template that is used by DDD and General Population staff. Staff will be educated on process. Process is as follows: 1. CM reviews daily census for inpatient admissions. 2. CM calls member while inpatient and discusses reason for admission and discharge plans. If member was admitted by provider other than PCP the CM contacts the PCP to notify of admit. 3. Upon discharge CM contacts member weekly to assess if discharge plan is adequate and coordinate any health care needs. 4. If member is unable to be contacted by phone a call is made to the provider and letters are sent to the member. 5. Post Discharge Management (stabilization) Care Plan is created. CM Process Improvement Series, a series of monthly educational meetings with the CM teams, will begin in	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	January 2025 with. Procedures will be reviewed to ensure adequate and appropriate discharge planning, as well as to address other IPRO audit deficiencies. Manager and senior care managers to attend daily rounds with the UM nurses and Medical Directors. Emphasize and reinforce timely CNA outreach and completion during the next CM Process Improvement Series meeting to be held in October 2024 with all CM teams. DCP&P Manager will utilize the DDD DCP&P Case list Report to identify and track new enrollees of the DCP&P population for the appropriate outreach to complete the CNA. For the DCP&P Population, reminders for EPSDT and dental exams added to the current CM audit tool. Revise EPSDT Reminder Letter to include targeted missing services and education on why it is important. Peer-to-peer CM audits for all populations for appropriate preventive services measures. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings. Monitor CM Documentation Report specifically for evidence of documentation related to preventive services. For new and existing DDD and DCP&P existing enrollees, reinforce communication, collaboration, and documentation of DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) through October and November 2024 team and round table meetings. CM Process Improvement Series, a series of monthly educational meetings with the CM teams, will begin in January 2025 with new approaches to educating teams, i.e., videos and reading assignments. Procedures will be reviewed to ensure adequate and appropriate contact with state staff, the members' family, PCPs, specialists, and LHD, to include coordinated needed care/services,	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	actively linking the Enrollee to providers, medical services, residential, social, community, and other support services for DCP&P new and existing enrollees as well as to address other IPRO audit deficiencies. NEW: Education to be provided to all DCP&P staff related to FindHelp Community Resources Link to locate available services. CM auditing process to ensure new and existing DCP&P members have the required documentation for new and existing members.	
WPNJ should address all deficiencies noted in the MLTSS – HCBS 2024 CM Review for elements within groups that scored below 86%.	**Member Outreach 9.6.2.A and 9.6.2.B** **WPNJ should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment (Group D).** Each clinical manager will provide oversight of initial outreaches to their own assigned team. The clinical manager will be conducting daily reviews of the initial outreach tracking grid. By closely monitoring the tracking grid, clinical managers will be able to identify and address any issues promptly and monitor risk of untimeliness in real time. In addition, a designated associate will highlight daily due outreaches and communicate this in real time to medical management specialists and clinical managers in a shared team site. Clinical managers will ensure that all scheduled outreaches are completed by the end of the business day. Wellpoint identified a delay in classifying newly enrolled members from the conversion population. To address this, a new queue has been established and will be monitored daily to promptly identify new members upon eligibility and ensure timely outreach. **Ongoing Care Management 9.6.5.B (1,2)** WPNJ should ensure that review of Member's placement and services occurs timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit) (Group C, D, E).	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	A weekly report has been developed listing all overdue cases and is distributed to clinical managers, for which managers provide status updates on each member. These updates are categorized and reviewed weekly by the clinical director. Additionally, clinical managers are closely monitoring upcoming cases to prevent overdue situations. The number of upcoming cases per care manager is evaluated to ensure workloads remain manageable. The MLTSS staffing model continues to be reviewed and revised as needed to align with present care management requirements, and additional positions have been requested to fulfill staffing needs. A monthly staffing report is reviewed by the Clinical Director and Human Resources to oversee staffing requirements per county. Additional recruiting strategies have been implemented in order to increase candidate applications. **Ongoing Care Management 9.6.4.H** WPNJ should ensure the Member has services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modifications are exempt from the 45 calendar day standard) (Group C & D). An update to the service verification workflow was made to set the due date of the post orientation task (service verification) to 45 days from enrollment. This due date was previously set to 45 days from initial visit, which may have pushed service verification out of compliance. With the implementation of HIP 2.0, Wellpoint will have the capability to pull reporting on the post orientation (Service verification) task completion. This reporting will be utilized to ensure that services are verified timely for each new member every month. The initial outreach call by Medical Management Specialists now includes an inquiry about existing services. Documentation guidelines have been updated to verify services during this initial contact, ensuring care managers have this information before their first visit with the member. **Ongoing Care Management 9.6.4**	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	WPNJ should ensure that Member files that indicate a change from the Initial Plan of Care have documentation that the Member's Plan of Care is updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signs and is provided with a copy of the Plan of Care (Group C). The service verification desktop process was updated to include guidance that a plan of care must be updated, signed and mailed if a change in services or a change in member condition is identified on this outreach 45 days from enrollment. Wellpoint has implemented a new internal process for continuous claims review to promptly identify service changes and update the plan of care. A "Service Delivery Report" is generated monthly to provide care management staff with detailed member claim information from service initiation. This report includes all HCBS service claims and the interval between claims. The data is stratified to help care managers identify true service gaps or changes of services for their members in order for the care manager to update the plan of care timely and mail it to the member. Education has been provided to staff regarding mailing of the plan of care each time that there is an update made. This re-education was conducted during the March 2025 MLTSS department meeting. Additionally, during each internal audit chart review, services are reviewed. If a change is identified, the auditor ensures an updated plan of care is completed, signed, and sent to the member. **Ongoing Care Management 9.6.5.F** **WPNJ should ensure for Members who are discharged to a HCBS setting the onsite review occurs within ten (10) days of discharge (Group D).** Enhanced outreach by the clinical MMS team has been implemented to ensure that discharges are captured and reported to care managers in real time. In addition to daily checks within our UM system to ensure that members remain hospitalized, the MMS team will conduct two telephonic outreaches to the hospital to inquire about a discharge plan per week. Once they are notified of	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	a discharge, the care manager will be alerted in real time in order to schedule a post hospitalization visit within 10 calendar days. Enhanced automatic SharePoint notifications to the care manager (and clinical manager) upon member's discharge from the hospital were implemented. The care manager and clinical manager will receive alerts upon member discharge from the hospital on Days 3, 5, and 7 post discharge. In addition, the Medical Management Specialists will task the care manager in the HIP system as soon as they are notified of the discharge. Upon notification, the care manager will outreach the member and schedule a face-to-face visit within 10 days of discharge. In the event the member refuses the face-to-face visit, the care manager will conduct a telephonic assessment with the member to review current needs and ensure there are no gaps in care. **Ongoing Care Management 9.6.5.F** **For the Member discharged to his/her own home, WPNJ should ensure in home services are in place timely (Group D & E).** At the post hospitalization visit, care managers complete all relevant documentation including the plan of care. Here, the care manager reviews all services authorized for the member to ensure that authorized services have begun. If the member is in need of additional services, the care manager will assess for services, update the plan of care and will place an urgent authorization. Education has been provided to staff regarding ensuring that services are in place for the member upon discharge. This re-education was conducted during the March 2025 MLTSS department meeting. **Ongoing Care Management 9.6.5.M** **For Members with a change in placement indicated, WPNJ should ensure there is documentation of a discussion with the Member before the change is made** (Group E). Once a positive nursing facility transition referral is entered, the transitions coordinator will contact the	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	member within three business days. This ensures members receive options counseling and the chance to use their transition benefits prior to leaving the facility. Enhanced outreach by the clinical MMS team has been implemented to ensure that care managers are notified of an anticipated discharge as soon as the discharge planning phase begins. Once the care manager is notified of a potential discharge date, they will outreach the member and/or family to confirm that they are comfortable with the planned discharge setting and that all services can be in place immediately following discharge. **Performance Measures 9.6.2 .D** **WPNJ should ensure the Initial Plan of Care is completed and a copy mailed to the Member/authorized representative within 45 days of MLTSS enrollment (Group C & D).** The Medical Management Specialists will track all new members for their respective teams from the time of enrollment through the time of visit completion. The Medical Management Specialists will send a status update on those cases by the 30th day of enrollment. The clinical management team will monitor this report and ensure that the initial visits are completed timely or that the unable to contact process is appropriately followed. New members who are unable to contact are followed closely by the clinical managers and a clinical compliance manager following enrollment. Outreaches and unannounced visits are completed as appropriate to ensure that every effort is made to complete care management visits within 45 days of enrollment.	
WPNJ should address all deficiencies noted in the MLTSS – NF/SCNF 2024 CM Review for elements that scored below 86%.	**Ongoing Care Management 9.6.5.B** **WPNJ MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members).** A weekly report has been developed listing all overdue cases and is distributed to clinical managers, for which managers provide status updates on each member. These	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	updates are categorized and reviewed weekly by the clinical director. The MLTSS staffing model continues to be reviewed and revised as needed to align with present care management requirements, and additional positions have been requested to fulfill staffing needs. A monthly staffing report is reviewed by the Clinical Director and Human Resources to oversee staffing requirements per county. Additional recruiting strategies have been implemented in order to increase candidate applications. **Reassessment of the Plan of Care and Critical Incident Reporting 9.6.1.E, 9.7.2.D** **WPNJ MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member and/or representative.** The service verification desktop process was updated to include guidance that a plan of care must be updated, signed and mailed if a change in service or a change in member condition is identified. Re-education has been provided to staff regarding mailing of the plan of care each time that there is an update made. This re-education was conducted during the March 2025 MLTSS department meeting. During each internal audit chart review, all services are reviewed. If a change is identified, the auditor ensures an updated plan of care is completed, signed, and sent to the member. **Ongoing Care Management 9.6.5.B.1** **WPNJ MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.** Nursing facility IDT meetings are documented under a task in HIP labeled "Nursing Facility IDT". With the implementation of HIP 2.0, Wellpoint will have the capability to obtain systematic reporting to capture Nursing Facility IDT meeting completion. The narrative template that care managers follow to document all visit elements with the member was	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	updated to include the date of the Nursing Facility IDT as a required field. The date of the care manager's participation in the nursing facility IDT is now a requirement to submit the visit narrative for a nursing facility member with the launch of HIP 2.0. Re-education was provided to the care management staff regarding participation of an annual NF IDT and documentation guidelines was held during the April 2025 MLTSS department meeting. **MLTSS Initial Plan of Care and Ongoing Plans of Care 9.6.2 .D** **WPNJ MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member within 45 days of MLTSS enrollment.** A designated Medical Management Specialist has been assigned to track all new members for the nursing facility team from the time of enrollment through the time of visit completion. The Medical Management Specialist will send a status update on those cases by the 30th day of enrollment. The NF Clinical Manager will monitor this report and ensure that the initial visits are completed timely and that members receive a copy of their plan of care within 45 days of enrollment. Members that are hospitalized or receiving therapies under their Medicare benefits at the time of enrollment are followed closely by the Medical Management Specialist team. The Medical Management Specialists conduct daily reviews of these cases and when a planned discharge is indicated, completes an outreach to the member to confirm discharge date and placement. Afterwards, a transition of care task will be entered to notify the care manager so that a timely visit can be conducted post-discharge. Upon receipt of the transition of care task, the care manager will complete a timely initial visit and POC mailing within 10 days of discharge. Members that are enrolled under a nursing facility living arrangement but found to reside in the community are closely monitored by the Medical Management Specialist. When identified, the clinical manager is made aware and appropriate actions are taken to reassign them immediately to a community care manager for an initial	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	visit. This ensures compliance with the initial visit and plan of care mailing, regardless of any living arrangement updates. After completing the initial visit, care managers send the plan of care to the member through our HIP 2.0 system. Wellpoint can generate reports on the completion of these mailings to ensure compliance with the turnaround time for the plan of care mailing. Care management re-education on timeliness of initial visit completion and POC mailing was completed at the March 2025 MLTSS department meeting.	

[1] **Addressed**: Managed Care Organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2026. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

MCO Strengths and Opportunities for Improvement, and EQR Recommendations

Table 64-Table 68 highlight each MCO's performance strengths and opportunities for improvement and this year's recommendations based on the aggregated results of the EQR activities conducted in 2025 as they relate to **quality**, **timeliness**, and **access**.

ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 64: ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2025 PIPs	Of the 6 PIPs scored, 4 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.	Overall, ABHNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions.
HEDIS MY 2024 Performance Measures	ABHNJ showed strengths in HEDIS quality related measures which were at or above the NCQA national 75th percentile.	ABHNJ should focus on the HEDIS quality-related measures which fell below the NCQA national 50th percentile.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2025, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 64% to 92%, did not meet compliance. Those standards were: Availability of services (92%) Coordination and continuity of Care (64%)
Network Adequacy – 2025 Provider Directory Validation	No strengths were identified.	ABHNJ should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	One (1) of eight (8) Child CHIP CAHPS measures fell between the 50th and 75th percentiles.	ABHNJ should focus on the CAHPS measures that fell below the NCQA national 50th percentile.
Core Medicaid - 2025 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, ABHNJ scored 85% or above in seven (7) categories ranging from 86.0% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, ABHNJ scored below the 85% threshold in six (6) categories ranging from 27.8% to 84.3%.
MLTSS – 2025 HCBS CM Review	Of the 6 categories at the sub-population level, ABHNJ scored at or above 86% for fourteen (14) of the seventeen (17) sub-populations scores.	Of the 6 categories at the sub-population level, ABHNJ scored below 86% for three (3) of the seventeen (17) sub-populations scores.

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
Recommendations	
2025 PIPs	ABHNJ should address the PIP validation elements that were determined to be partially met.
HEDIS MY 2024 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	**Access** 1. A7. ABHNJ should focus on improving appointment availability for OB/GYNs, Specialists, and Behavioral Health providers, as well as after-hours non-compliance. 2. A8. ABHNJ should ensure to follow instructions provided by the EQRO prior to submitting pre-audit documentation.
Network Adequacy – 2025 Provider Directory Validation	1. ABHNJ should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. ABHNJ should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. 2. ABHNJ should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. 3. ABHNJ should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. 4. ABHNJ should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	The MCO should continue to work to improve Adult, Child, Child CCC, Child CHIP, and Child CHIP CCC CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2025 CM Review	ABHNJ should address the deficiencies noted in the following areas: **For the General Population:** 1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to new Enrollees). 2. CM6: For an IHS not completed timely or no IHS on file, ABHNJ should ensure that aggressive outreach attempts are performed and documented within 45 days of the Enrollee's MCO enrollment date (applies to new Enrollees). 3. CM7: *File Audit*: For Enrollees who are lost to contact, ABHNJ should ensure that aggressive outreach attempts are made and documented by the Care Manager (applies to existing Enrollees). 4. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees). 5. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure that appropriate outreach attempts are documented to confirm immunization status (applies to existing Enrollees).

6. CM14: For Enrollees aged 19 and above, ABHNJ should ensure that appropriate outreach attempts are documented to confirm vaccination status (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that appropriate outreach attempts are documented to confirm dental status (applies to new Enrollees).
8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that the Care Manager sends dental reminders (applies to new and existing Enrollees).
9. CM15: ABHNJ should ensure that for Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan is documented to address the Enrollee's specific care needs (applies to new Enrollees).

For the DDD Population:

1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM7: ABHNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
3. CM8: ABHNJ should ensure that the Enrollee has a Care Plan that was developed within 30 days of CNA completion (applies to new Enrollees).
4. CM8: *File Audit:* ABHNJ should ensure that the Enrollee has a Care Plan of file during the review period (applies to existing Enrollees).
5. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure that appropriate outreach attempts are documented to confirm EPSDT status when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees).
6. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure that appropriate outreach attempts are documented to confirm immunization status (applies to existing Enrollees).
8. CM14: For Enrollees aged 19 and above, ABHNJ should ensure that appropriate outreach attempts are documented to confirm vaccination status (applies to new and existing Enrollees).
9. CM14: For Enrollees aged 21 and above, ABHNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees).
10. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should document appropriate outreach attempts to confirm dental status for Enrollees (applies to new and existing).
11. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that dental reminders are sent (applies to new and existing Enrollees).
12. CM19: ABHNJ should ensure that when appropriate for the applicable Enrollees, Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to new and existing Enrollees).

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	13. CM37: ABHNJ should establish a quality improvement process to ensure compliance and accuracy with audit preparation and submissions to the EQRO. **For the DCP&P Population:** 1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM7 *File Audit:* ABHNJ should ensure the CNA is completed timely, within 45 days of Enrollee's MCO enrollment date (applies to new Enrollees). 3. CM8 *File Audit:* ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees). 4. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, ABHNJ should ensure that the Care Manager makes appropriate outreach attempts to confirm EPSDT status (applies to new Enrollees). 5. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, ABHNJ should ensure EPSDT reminders are sent (applies to new and existing Enrollees). 6. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure appropriate outreach attempts are made to confirm immunization status (applies to new and existing Enrollees). 7. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should document appropriate outreach attempts to confirm dental status for Enrollees (applies new to existing Enrollees). 8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure dental reminders are sent (applies to new and existing Enrollees). 9. CM19: For Enrollees demonstrating needs requiring coordination of services, ABHNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).
MLTSS – 2025 HCBS CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B.**

FC/WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 65: FC/WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2025 PIPs	Of the 4 PIPs scored, 1 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.	Overall, FC/WCHP was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring barrier analyses are comprehensive and drive appropriate interventions and sufficiently address factors that impact external validity of performance indicator results.

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
		One (1) Core Medicaid PIP scored below the 85% threshold.
HEDIS MY 2024 Performance Measures	FC/WCHP showed strengths in HEDIS quality related measures which were at or above the NCQA national 75th percentile.	FC/WCHP should focus on the HEDIS quality-related measures which fell below the NCQA national 50th percentile.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2025, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 73% to 83%, did not meet compliance. Those standards were: Availability of services (83%) Coordination and continuity of Care (73%)
Network Adequacy – 2025 Provider Directory Validation	No strengths were identified.	FC/WCHP should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their specific needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	One (1) of the eight (8) Adult CAHPS measures fell between the 75th and 90th percentiles. One (1) of the eight (8) Child CAHPS measures fell between the 50th and 75th percentiles. One (1) Child CAHPS measure was at or above the 90th percentile. Three (3) of the eight (8) Child CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) Child CCC CAHPS measure fell between the 75th and 90th percentiles. One (1) Child CCC CAHPS measure was at or above the 90th percentile. One (1) of the eight (8) Child CHIP CAHPS measures fell between the 50th and 75th percentiles. Two (2) Child CHIP CAHPS measures fell between the 75th and 90th percentiles. One (1) Child CHIP CAHPS measure was at or above the 90th percentile. Two (2) of eleven (11) Child CHIP CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) Child CHIP CCC CAHPS measure fell between the 75th and 90th percentiles. Two (2) Child CHIP CCC CAHPS measures were at or above the 90th percentile.	FC/WCHP should focus on the CAHPS measures that fell below the NCQA national 50th percentile.
Core Medicaid - 2025 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, FC/WCHP scored	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, FC/WCHP

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
	over the 85% threshold in ten (10) categories ranging from 92.2% to 100.0%.	scored below the 85% threshold in three (3) categories ranging from 50.0% to 72.4%.
MLTSS – 2025 HCBS CM Review	Of the 6 categories at the sub-population level, FC/WCHP scored at or above 86% for thirteen (13) of the seventeen (17) sub-populations scores.	Of the 6 categories at the sub-population level, FC/WCHP scored below 86% for four (4) of the seventeen (17) sub-populations scores.
Recommendations		
2025 PIPs	FC/WCHP should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2024 Performance Measures	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, FC/WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	**Access** 1. A4d. Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for Oral Surgeons in Burlington, Middlesex, and Passaic counties. 2. A7. Fidelis Care should focus on improving appointment availability for Adult PCPs, Pediatric PCPs, OB/GYNs, Specialists, and Behavioral Health Providers, as well as after-hours non-compliance. 3. A8. Fidelis Care should ensure compliance with the instructions for submitting Provider Network submissions to DMAHS, including providing evidence of submission and any associated waiver requests. **Satisfaction** 1. S5. Fidelis Care should develop a system to conduct and track quarterly surveys to new enrollees to verify the enrollees' understanding of the Contractor's procedures and services available. 2. S5. The MCO should have a tracking methodology in place to submit to DMAHS or the EQRO upon request.	
Network Adequacy – 2025 Provider Directory Validation	1. Fidelis Care should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. Fidelis Care should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. 2. Fidelis Care should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. 3. Fidelis Care should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. 4. Fidelis Care should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.	

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
Quality-of-Care Surveys – Member (CAHPS MY 2024)	The MCO should continue to work to improve Adult, Child, Child CCC, Child CHIP, and Child CHIP CCC CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2025 CM Review	FC/WCHP should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: For an IHS not completed timely or no IHS on file, Fidelis Care should ensure that aggressive outreach attempts are performed and documented within 45 days from the Enrollee's MCO enrollment date (applies to new Enrollees). 2. CM7: For CNAs not completed timely or no CNA on file, Fidelis Care should ensure that aggressive efforts are made to complete the CNA within 30 days of identification of CM needs (applies to new Enrollees). 3. CM7 *File Audit:* Fidelis Care should ensure that a CNA is completed timely, within 30 days of identification of CM needs (applies to new Enrollees). **For the DDD Population:** 1. CM2: Fidelis Care should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM14: For Enrollees aged 0 through 18, Fidelis Care should ensure that appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees). 3. CM14: For Enrollees aged 19 and above, Fidelis Care should ensure that appropriate outreach attempts to confirm vaccination status are documented (applies to existing Enrollees). 4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees). 5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure dental reminders are sent (applies to existing Enrollees). **For the DCP&P Population:** 1. CM7: For CNAs not completed timely or no CNA on file, Fidelis Care should ensure that aggressive efforts are made to complete the CNA within 45 days of MCO enrollment (applies to new Enrollees). 2. CM7 *File Audit:* Fidelis Care should ensure the CNA is completed timely, within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees). 3. CM8 *File Audit:* Fidelis Care should ensure that the Enrollee has a Care Plan on file during the review period (applies to new Enrollees).
MLTSS – 2024 HCBS CM Review	FC/WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.

HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 66: HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
2025 PIPs	Of the 5 PIPs scored, 3 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.	Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions.
HEDIS MY 2024 Performance Measures	HNJH showed strengths in HEDIS quality related measures which were at or above the NCQA national 75th percentile.	HNJH should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2025, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 64% to 92%, did not meet compliance. Those standards were: Availability of services (92%) Coordination and continuity of Care (64%)
Network Adequacy – 2025 Provider Directory Validation	No strengths were identified.	HNJH should consider including additional accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	Three (3) of eight (8) Adult CAHPS measures were at or above the 90th percentile. One (1) Adult CAHPS measure fell between the 50th and 75th percentiles. One (1) Adult CAHPS measure fell between 75th and 90th percentiles. One (1) of eight (8) Child CAHPS measures fell between 75th and 90th percentile. One (1) Child CAHPS measure fell between the 50th and 75th percentiles. Two (2) of the eleven (11) Child CCC CAHPS measures fell between the 75th and 90th percentiles. One (1) Child CCC CAHPS measure fell between the 50th and 75th percentiles. Two (2) of eight (8) Child CHIP CAHPS measures fell between the 50th and 75th percentile. One (1) Child CHIP CAHPS measure fell between the 75th and 90th percentile. One (1) of eleven (11) Child CHIP CCC CAHPS measure fell between the 50th and 75th percentile. One (1) Child CHIP CCC CAHPS measure fell between the 75th and 90th percentiles.	HNJH should focus on the CAHPS measures that fell below the NCQA national 50th percentile.
Core Medicaid - 2025 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, HNJH scored over	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, HNJH

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
	the 85% threshold in nine (9) categories ranging from 87.7% to 100%.	scored below the 85% threshold in four (4) categories ranging from 50.0% to 77.5%.
MLTSS – 2025 HCBS CM Review	Of the 6 categories at the sub-population level, HNJH scored at or above 86% for thirteen (13) of the seventeen (17) sub-populations scores.	Of the 6 categories at the sub-population level, HNJH scored below 86% for four (4) of the seventeen (17) sub-populations scores.
Recommendations		
2025 PIPs	HNJH should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2024 Performance Measures	1. The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	**Access** 1. A7. HNJH should focus on improving appointment availability for Adult PCPs, OB/GYNs, Specialists, Behavioral Health providers, as well as after-hours non-compliance. 2. A8. HNJH should ensure to follow instructions provided by the EQRO prior to submitting pre-audit documentation.	
Network Adequacy – 2025 Provider Directory Validation	1. As provider directory accuracy rates declined from 2024 to 2025, HNJH should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. HNJH should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. 2. HNJH should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. 3. HNJH should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. 4. HNJH should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.	
Quality-of-Care Surveys – Member (CAHPS MY 2024)	The MCO should continue to work to improve Adult, Child, Child CCC, Child CHIP, and Child CHIP CCC CAHPS scores that perform below the 50th percentile.	
Core Medicaid - 2025 CM Review	HNJH should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: For an IHS not completed timely or no IHS on file, HNJH should ensure that aggressive outreach attempts are performed and documented within 45 days from the Enrollee's MCO enrollment date (applies to new Enrollees). 2. CM7: HNJH should ensure aggressive efforts are made to complete CNAs within 30 days of identification of CM needs (applies to new Enrollees). **For the DDD Population:** 1. CM7: *File Audit*: HNJH should ensure that the CNA is completed timely, within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees). 2. CM8: *File Audit*: HNJH should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).	

3. CM8: HNJH should ensure that the Enrollee's Care Plan includes all required components (applies to existing Enrollees).
4. CM11: HNJH should ensure that the Enrollees Care Plan is reviewed/monitored during the review period. At a minimum annually (applies to existing Enrollees).
5. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, HNJH should ensure that appropriate outreach attempts to confirm EPSDT status are documented (applies to existing Enrollees).
6. CM14: For Enrollees aged 0 through 20, HNJH should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees).
7. CM14: For Enrollees aged 0 through 18, HNJH should ensure that appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees).
8. CM14: For Enrollees aged 19 and above, HNJH should ensure that appropriate outreach attempts to confirm vaccination status are documented (applies to existing Enrollees).
9. CM14: For Enrollees aged 21 and above, HNJH should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees).
10. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees).
11. For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees).
12. CM19: HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to new and existing Enrollees).

For the DCP&P Population:

1. CM8 *File Audit*: HNJH should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).
2. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, HNJH should ensure that the Care Manager makes appropriate outreach attempts to confirm EPSDT status (applies to existing Enrollees).
3. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, HNJH should ensure EPSDT reminders are sent (applies to existing Enrollees).
4. CM14: For Enrollees aged 0 through 18, HNJH should ensure appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees).
5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees).
6. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees).
7. CM19: HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
	(PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
MLTSS – 2024 HCBS CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D.**

UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 67: UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2025 PIPs	Of the 5 PIPs scored, 2 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.	Overall, UHCCP was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions. One (1) Core Medicaid PIP scored below the 85% threshold.
HEDIS MY 2024 Performance Measures	UHCCP showed strengths in HEDIS quality related measures which were at or above the NCQA national 75th percentile.	UHCCP should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2025, ten (10) standards received 100% compliance.	Four (4) standards, ranging from 67% to 82%, did not meet compliance. Those standards were: Disenrollment (78%) Enrollee Rights (67%) Availability of services (75%) Coordination and continuity of Care (82%)
Network Adequacy – 2025 Provider Directory Validation	No strengths were identified.	UHCCP should include clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility needs.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	One (1) of eleven (11) Child CCC CAHPS measure fell between the 50th and 75th percentiles. One (1) Child CHIP CAHPS measures fell between the 50th and 75th percentiles.	UHCCP should focus on the CAHPS measures that fell below the NCQA national 50th percentile.
Core Medicaid - 2025 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, UHCCP scored over the 85% threshold in twelve (12) categories ranging from 93.3% to 100%.	One (1) category (Outreach) was N/A as no DCP&P enrollees met criteria for this measure as all CNAs were completed timely.
MLTSS – 2025 HCBS CM Review	Of the 6 categories at the sub-population level, UHCCP scored at or above 86% for nine (9) of the seventeen (17) sub-populations scores.	Of the 6 categories at the sub-population level, UHCCP scored below 86% for eight (8) of the seventeen (17) sub-populations scores.
Recommendations		

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
2025 PIPs	UHCCP should address the PIP validation elements that were determined to be partially met.
HEDIS MY 2024 Performance Measures	Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	**Access** 1. A3. UHCCP should provide documentation that has been created or revised within the specified review timeframe. 2. A4f. UHCCP should continue to expand the MLTSS network to include at least two providers in every County for Adult Medical Day Care in Cape May, Hunterdon, Sussex, and Warren Counties. 3. A7. UHCCP should focus on improving appointment availability for OB-GYNs, High Volume Specialists, Behavioral Health Providers, as well as after-hours non-compliance. **Enrollee Rights and Responsibilities** 1. ER4. UHCCP should amend the Readability and Language Spoken policy to include language requiring that prose is readable and easily understood at a 5th grade reading level using a font size no smaller than 12 points. **Member Disenrollment** 1. MD2. UHCCP should provide documentation that contains all required contractual language and must be created or revised within the designated review period. 2. MD10. UHCCP should provide documentation that has been created or revised within the specified review timeframe.
Network Adequacy – 2025 Provider Directory Validation	1. As the provider directory access rate improved from 2024 to 2025, UHCCP should continue with routine assessments verifying provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. UHCCP should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. 2. As the provider directory board certification rates declined from 2024 to 2025, UHCCP should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. 3. As the provider directory disability accuracy rates declined from 2024 to 2025, UHCCP should routinely review and update the accessibility options listed in providers' profiles to maintain accuracy. 4. UHCCP should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	The MCO should continue to work to improve Adult, Child, Child CCC, Child CHIP, and Child CHIP CCC CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2025 CM Review	UHCCP should address the deficiencies noted in the following areas: **For the General Population:**

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. CM6: For an IHS not completed timely or no IHS on file, UHCCP should ensure that aggressive outreach attempts are performed and documented within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees). **For the DDD Population:** 1. CM2: For Enrollees who are hospitalized, UHCCP should ensure that adequate discharge planning is performed (applies to new Enrollees). 2. CM17: For Enrollees with a comprehensive treatment plan, UHCCP should ensure the treatment plan progresses in a timely manner without unreasonable interruption (applies to new Enrollees). **For the DCP&P Population:** 1. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, UHCCP should ensure EPSDT reminders are sent (applies to existing Enrollees). 2. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, UHCCP should ensure dental reminders are sent (applies to new Enrollees).
MLTSS – 2024 HCBS CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E.**

WPNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 68: WPNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2025 PIPs	Of the 5 PIPs scored, 3 PIPs performed at or above the 85% threshold for Core Medicaid, indicating high performance; 2 PIPs scored above the 86% threshold for MLTSS, indicating high performance.	Overall, WPNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include reevaluation of barrier analyses to inform enhanced or new interventions.
HEDIS MY 2024 Performance Measures	WPNJ showed strengths in HEDIS quality related measures which were at or above the NCQA national 75th percentile.	WPNJ should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile.
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2025, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 82% to 92%, did not meet compliance. Those standards were: Availability of services (92%) Coordination and continuity of Care (82%)
Network Adequacy – 2025 Provider Directory Validation	No strengths were identified.	No opportunities for improvement were identified.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	One (1) of the eight (8) Adult CAHPS measures fell between the 75th and 90th percentiles. One (1) Adult CAHPS measure fell between the 50th and 75th percentiles. Three (3) of eight (8) Child	WPNJ should focus on the CAHPS measures that fell below the NCQA national 50th percentile.

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
	CAHPS measures fell between the 50th and 75th percentiles. Five (5) of the eleven (11) Child CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) Child CCC CAHPS measure fell between 75th and 90th percentiles. Three (3) Child CHIP CAHPS measures fell between the 50th and 75th percentile.	
Core Medicaid - 2025 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, WPNJ scored over the 85% threshold in ten (10) categories ranging from 90.5% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, WPNJ scored below the 85% threshold in two (2) categories ranging from 72.0% to 83.5%. One (1) category (Outreach) was N/A as no DCP&P enrollees met criteria for this measure as all CNAs were completed timely.
MLTSS – 2025 HCBS CM Review	Of the 6 categories at the sub-population level, WPNJ scored at or above 86% for eleven (11) of the seventeen (17) sub-populations scores.	Of the 6 categories at the sub-population level, WPNJ scored below 86% for six (6) of the seventeen (17) sub-populations scores.
Recommendations		
2025 PIPs	WPNJ should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2024 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WPNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
2025 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2024, to June 30, 2025*)*	**Access** 1. A7. WPNJ should focus on improving appointment availability for Other Specialists, Behavioral Health Prescribers, and Behavioral Health Non-Prescribers. **Credentialing and Re-credentialing** 2. CR9 The MCO should ensure to send timely credentialing notification letters to providers.	
Network Adequacy – 2025 Provider Directory Validation	1. As the provider directory accuracy rates improved from 2024 to 2025, WPNJ should continue with routine assessments to validate provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. WPNJ should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. 2. As the provider directory board certification rates improved from 2024 to 2025, WPNJ should continue to update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. 3. As the provider directory disability accuracy rates declined from 2024 to 2025, WPNJ should routinely review and update the accessibility options listed in providers' profiles to maintain accuracy.	

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	4. WPNJ should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.
Quality-of-Care Surveys – Member (CAHPS MY 2024)	The MCO should continue to work to improve Adult, Child, Child CCC, Child CHIP, and Child CHIP CCC CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2025 CM Review	WPNJ should address the deficiencies noted in the following areas: **For the General Population:** 1. CM7: For CNAs not completed timely or no CNA on file, WPNJ should ensure aggressive efforts are made to complete the CNA within 30 days of identification of CM needs (applies to existing Enrollees). 2. CM7 *File Audit:* WPNJ should ensure that a CNA is completed timely, within 30 days of identification of CM needs (applies to new Enrollees). 3. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees). 4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, WPNJ should ensure that dental reminders are sent (applies to existing Enrollees). **For the DDD Population:** 1. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees). 2. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollee's EPSDT exam is not up to date (applies to new and existing Enrollees). 3. CM14: For Enrollees aged 19 and above, WPNJ should ensure appropriate outreach attempts are made to confirm vaccination status (applies to existing Enrollees). 4. CM14: For Enrollees aged 21 and above, WPNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees). **For the DCP&P Population:** 1. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees). 2. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees). 3. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
MLTSS – 2025 HCBS CM Review	WPNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.

Appendix A: January 2025 – December 2025 NJ MCO-Specific Review Finding

Note: This is a separate document.

Appendix B: ABHNJ 2025 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix C: FC/WCHP 2025 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix D: HNJH 2025 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix E: UHCCP 2025 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix F: WPNJ 2025 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix G: 2025 Network Adequacy Provider Directory Validation Surveys

Note: This is a separate document.

Appendix H: Supplemental Documents for all MCOs: Submission Guide for 2025 Annual Assessment, 2025 Care Management Audits (Core Medicaid and MLTSS).

Note: This is a separate document.

APPENDIX A: January 2025–December 2025 NJ MCO-Specific Review Findings (2025 – 2026 Reporting Cycle)

APPENDIX A: January 2025–December 2025 NJ MCO-Specific Review Findings (2025 – 2026 Reporting Cycle)

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ABHNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

ABHNJ 2025 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	22	8	0	22	73%
Care Management and Continuity of Care – MLTSS*	10	0	10	10	0	0	0	100%
Access**	12	0	12	10	2	0	10	83%
Emergency and Post-Stabilization Services	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	0	21	20	1	0	20	95%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	0	9	9	0	0	9	100%
Programs for the Elderly and Disabled	44	0	44	44	0	0	44	100%
Provider Training and Performance	11	0	11	11	0	0	11	100%
Satisfaction	5	0	5	5	0	0	5	100%
Enrollee Rights and Responsibilities	8	0	8	8	0	0	8	100%
Member Disenrollment	29	0	29	29	0	0	29	100%
Credentialing and Re-credentialing	10	0	10	10	0	0	10	100%
Utilization Management	30	0	30	30	0	0	30	100%
Administration and Operations	14	0	14	14	0	0	14	100%
Management Information Systems	18	0	18	18	0	0	18	100%
TOTAL	**232**	**0**	**232**	**229**	**3**	**0**	**229**	**99%**

[1] A total of 97 elements were reviewed in the previous review period; of these 97, 93 were *Met,* 4 were *Not Met*; 0 were *N/A.* Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period.

[3] 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.

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

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

**Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services.

ABHNJ Performance Improvement Projects

ABHNJ PIP 1: Improving Access and Availability to Primary Care for the Medicaid Population

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

PIP Topic 1: Improving Access and Availability to Primary Care for the Medicaid Population

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**72.5**	**87.5**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**72.5%**	**87.5%**

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org); Carolyn Gallagher (cgallagher@ipro.org)
Date (report submission) reviewed: October 8, 2025
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is partially compliant. For element 2a, the table on pg. 9 does not align with Table 2 on pg. 55 The Final Goal for Indicators 3 and 4 are looking for a decrease in a rate, yet the Final Goals list a higher rate than the baseline.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant. For element 8b, while the MCO showed progress in increasing PCP utilization for targeted adult PCPs and met their goal, the remaining PI's around increasing PIP utilization for all PCPs and reducing ED utilization for the targeted PCPs and the Medicaid network declined and did not meet goal/target and continued to move in the opposite of the intended direction for this PIP.

Element 9 Overall Review Determination was that healthcare disparities are not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 87.5 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has implemented a number of member- and provider-focused interventions aimed at increasing PCP utilization and decreasing ED utilization (for LANE diagnoses). During the course of the project, the Plan has uncovered some information related to members seeing a PCP that differs from their assigned PCP and is working on a project to address this discrepancy, making the ongoing reporting of metrics more precise. The Plan is also actively recruiting additional provider groups to sign an AVIP (VBS) contracts that contains member engagement requirements. The MCO has committed to continue to review data and to develop new interventions to address additional barriers identified.

ABHNJ PIP 2: Increasing Early and Periodic Screening Diagnostic and Treatments (EPSDT) Visits and Childhood Immunizations

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

PIP Topic 2: Increasing Early and Periodic Screening Diagnostic and Treatments (EPSDT) Visits and Childhood Immunizations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**75.0**	**90.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**75.0%**	**90.0%**

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

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 9/18/25
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was partially compliant with element 8b. Sustained improvement was clearly demonstrated for well-child visit indicators (1 & 2), but not for immunization indicators (3 & 4), where improvement was inconsistent and goals were not achieved.

Element 9 Overall Review Determination was that healthcare disparities are identified, evaluated, and addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO focused on African-American children and practices serving this population, showing sustained improvement in well-child visits but inconsistent gains in immunizations. Interventions were informed by barrier analysis and expanded (e.g., IVR+SMS, provider outreach), and the MCO attempted to seek additional member feedback. Continued opportunity remains to systematically assess and address SDOH barriers to strengthen sustainability.

ABHNJ PIP 3: Decreasing Member Grievances Related to Balance Billing

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

PIP Topic 3: Decreasing Member Grievances Related to Balance Billing

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**N**	N		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**87.5%**	**0%**	**0%**

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

IPRO Reviewers: Chris Relyea (crelyea@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 16, 2025
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is partially compliant. For Element 2c, objectives should be updated to align with updates to ITMs. For example, the interventions are targeting providers with 4 or more grievances (no longer 10 or more) and there is no longer an intervention sending rosters to providers who have 4-9 member grievances.

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant. For Element 5d, ITM 1a1 Table 1b there is an undefined footnote (15) for Y2 Q2 data. ITM 1a6 in Table 1b is not matching ITM 1a6 Table 1a.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities were not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70.0 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please note, there was a rounding discrepancy for Performance Indicator #4; the baseline calculation was rounded to 4.14 instead of 4.15. Please correct in future submissions.
The MCO continues to make changes into the second year, taking time to review every aspect of the PIP, and using the QI process to make appropriate changes in each area when needed. Please address the comments provided above in future submissions.

ABHNJ PIP 4: Increasing IMA Combination 2 Vaccinations and Well Child Visits

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

PIP Topic 4: Increasing IMA Combination 2 Vaccinations and Well Child Visits

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M			
7d. Lessons learned & follow-up activities planned as a result	N/A	M			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org), Deb Chambers (dchambers@ipro.org)
Date reviewed: October 14, 2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant. For reporting consistency, IPRO recommends updating the Goal(s) table (pg.9) within Section 3.2 to reflect the change in the Indicator 3 long-term goal rate from 61.15% to 70.08%.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

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

Element 9 Overall Review Determination was that Healthcare disparities have been identified, evaluated and addressed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). Related to Element 2, as mentioned above, for reporting consistency, IPRO recommends updating the Goal(s) table (pg.9) within Section 3.2 to reflect the change in the Indicator 3 long-term goal rate from 61.15% to 70.08%. In Section 5, Table 1b, ITM 1a, the Y1, Q1 2025 calculation 119/316=37.66%, not 36.66% as reported. Also, the cover page lists January 2025 as the year of the PIP, instead of September 2024, as per the new template. Please make these corrections for future submissions. All IPRO's previous PIP review recommendations have been implemented into the August 2025 report.

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

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

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

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**72.5**	**100.0**	**100.0**
Overall Rating	**N/A**	**100.0%**	**90.6%**	**100.0%**	**100.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/6/2025
Reporting Period: Year 4

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. Please note that for ITM4a SYQ4 (2024) both in the addendum table and the write-up on page 34 of the overall submission, there is a calculation error stating that 7/9=55.56% and should be reflected as 77.78%.

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that healthcare disparities are being identified and reviewed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). Please review comments provided above and apply for future PIPs to ensure that all calculations and data provided in explanations is accurate.

ABHNJ PIP 6: Increasing the number of 10-day post-discharge visits with assessment for the MLTSS population

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

PIP Topic 6: Increasing the number of 10-day post-discharge visits with assessment for the MLTSS population

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

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

Element 7. Discussion and Validity of Reported Improvement 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	N/A			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
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**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**N**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**0%**	**0%**	**0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/7/2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. In future submissions, please correct the rate for ITM 5a on page 32 (4.76%) to match the calculation in Table 1b (7.14%).

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

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

Element 8 Overall Review Determination is N/A. Sustainability is not evaluated during the interim phase.

Element 9 Overall Review Determination is "N". Evidence of healthcare disparities being identified, evaluated and/or addressed was not presented within the interim report.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). All IPRO's previous PIP review recommendations have been implemented into the August report. Please see comment above for Element 5 and correct in next submission.

ABHNJ HEDIS Audit Review Table MY 2024

Audit Review Table					
Aetna Better Health of New Jersey (Org ID: 236303, Sub ID: 15442, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2024; Date & Timestamp - 5/30/2025 1:06:05 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		90.75%	R	R	Reported
Counseling for Nutrition (Total)		81.75%	R	R	Reported
Counseling for Physical Activity (Total)		80.29%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		67.64%	R	R	Reported
IPV		83.21%	R	R	Reported
MMR		79.32%	R	R	Reported
HiB		82.97%	R	R	Reported
Hepatitis B		82.24%	R	R	Reported
VZV		79.56%	R	R	Reported
Pneumococcal Conjugate		64.48%	R	R	Reported
Hepatitis A		71.05%	R	R	Reported
Rotavirus		67.15%	R	R	Reported
Influenza		41.12%	R	R	Reported
Combo 3		57.66%	R	R	Reported
Combo 7		48.42%	R	R	Reported
Combo 10		29.93%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		82.73%	R	R	Reported
Tdap		84.91%	R	R	Reported
HPV		29.44%	R	R	Reported
Combination 1		81.75%	R	R	Reported
Combination 2		28.22%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		77.62%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		53.53%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		66.39%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		21.81%	R	R	Reported
(3-5)		54.33%	R	R	Reported
(6-14)		59.81%	R	R	Reported
(15-20)		42.64%	R	R	Reported
(Total)		49.00%	R	R	Reported
Topical Fluoride for Children (TFC)					
(1-2)		14.62%	R	R	Reported

(3-4)		23.45%	R	R	Reported
(Total)		19.09%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		82.08%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		79.23%	R	R	Reported
Bronchodilator		85.46%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		66.42%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		71.05%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		51.85%	NA	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		75.68%	R	R	Reported
Statin Adherence 80% (Total)		71.29%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		2.20%	R	R	Reported
Engagement1 (Total)		4.40%	R	R	Reported
Engagement2 (Total)		4.95%	R	R	Reported
Achievement (Total)		2.75%	R	R	Reported
Glycemic Status Assessment for Patients With Diabetes (GSD)					
Glycemic Status <8.0%		63.02%	R	R	Reported
Glycemic Status >9.0%		26.28%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		74.70%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		55.23%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		42.60%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		64.21%	R	R	Reported
Statin Adherence 80%		64.17%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		26.61%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Effective Acute Phase Treatment		64.05%	R	R	Reported
Effective Continuation Phase Treatment		49.30%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		41.96%	R	R	Reported
7 days (Total)		22.28%	R	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		57.22%	R	R	Reported
7 days (Total)		44.58%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		3.51%	R	R	Reported
Opioid (Total)		4.15%	R	R	Reported
Other (Total)		4.38%	R	R	Reported
Any (Total)		8.27%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		45.66%	R	R	Reported
7 Days (Total)		23.89%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		40.94%	R	R	Reported
7 days (Total)		29.84%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		25.54%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		86.68%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		70.37%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		66.67%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		68.91%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		85.29%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		56.91%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		72.22%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		11.79%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		24.07%	R	R	Reported
Multiple Pharmacies		2.91%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.94%	R	R	Reported

Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		6.46%	R	R	Reported
>=31 Days (Total)		4.63%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		75.18%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		56.45%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		26.58%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		86.86%	R	R	Reported
Postpartum Care		83.21%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		57.53%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		57.78%	R	R	Reported
(15 Months-30 Months)		74.60%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		62.33%	R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		24.42%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		60.77%	R	R	Reported
IPV		73.85%	R	R	Reported
MMR		80.65%	R	R	Reported
HiB		76.41%	R	R	Reported
Hepatitis B		49.37%	R	R	Reported
VZV		80.28%	R	R	Reported
Pneumococcal Conjugate		55.91%	R	R	Reported
Hepatitis A		69.77%	R	R	Reported
Rotavirus		56.49%	R	R	Reported
Influenza		38.02%	R	R	Reported
Combo 3		33.73%	R	R	Reported
Combo 7		26.73%	R	R	Reported
Combo 10		16.00%	R	R	Reported
Immunizations for Adolescents (IMA-E)					

Meningococcal		80.97%	R	R	Reported
Tdap		83.35%	R	R	Reported
HPV		23.79%	R	R	Reported
Combination 1		79.52%	R	R	Reported
Combination 2		21.84%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		49.89%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		49.50%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		42.02%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		43.16%	R	R	Reported
Continuation and Maintenance Phase		53.13%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		60.22%	R	R	Reported
Cholesterol Testing (Total)		45.30%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		44.75%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		10.36%	R	R	Reported
Follow-Up on Positive Screen (Total)		80.90%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		12.37%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Follow-Up PHQ-9 (Total)		13.04%	R	R	Reported
Depression Remission (Total)		8.70%	R	R	Reported
Depression Response (Total)		13.04%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		9.81%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	R	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (Total)		16.12%	R	R	Reported
Td/Tdap (Total)		22.72%	R	R	Reported
Zoster (Total)		9.28%	R	R	Reported
Pneumococcal (66+)		35.53%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		18.58%	R	R	Reported
Tdap		41.36%	R	R	Reported
Combination		13.64%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		10.23%	R	R	Reported
Follow-Up on Positive Screen		25.00%	NA	R	Reported

Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		26.84%	R	R	Reported
Follow-Up on Positive Screen		36.36%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		1.76%	R	R	Reported
Food Intervention (Total)		45.33%	R	R	Reported
Housing Screening (Total)		6.82%	R	R	Reported
Housing Intervention (Total)		0.00%	R	R	Reported
Transportation Screening (Total)		4.69%	R	R	Reported
Transportation Intervention (Total)		0.00%	R	R	Reported

FC/WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

FC/WCHP 2025 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	26	4	0	26	87%
Care Management and Continuity of Care – MLTSS*	10	0	10	10	0	0	0	100%
Access**	12	3	9	66	3	0	9	75%
Emergency and Post-Stabilization Services	6	4	2	2	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	11	1	0	20	95%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	2	1	0	4	80%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment	29	24	5	5	0	0	29	100%
Credentialing and Re-credentialing	10	7	3	3	0	0	10	100%
Utilization Management	30	16	14	14	0	0	30	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**232**	**140**	**92**	**95**	**5**	**0**	**227**	**98%**

[1] A total of 232 elements were reviewed in the previous review period; of these 232, 220 were Met, 12 were Not Met; 0 were N/A. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period.

[3] 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.

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

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

**Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services.

FC/WCHP Performance Improvement Projects

FC/WCHP PIP 1: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 1: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**62.5**	**82.5**	**82.5**
Overall Rating	**N/A**	**75.0%**	**78.1%**	**82.5%**	**82.5%**

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

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 18, 2025
Report Status: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant with elements 5a and 5b. Interventions 2 and 6 (aimed at guardians with difficulty keeping pediatric appointments) were discontinued and the Final Report did not document a replacement intervention. While the Plan noted that a new intervention to address office-hour barriers may be considered in the future, no additional intervention was implemented during the reporting period. The Final Report indicates that interventions remained largely focused on Care Management enrollees and there is no evidence that the Plan implemented broader, population-wide strategies to reach non–care managed members, limiting the overall impact of the PIP.

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

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

Element 8 Overall Review Determination was partially compliant for element 8b. Indicator #1 (well-child visits gaps in care) showed some improvement from 2021 to 2023, but Indicator #2 (CIS care gaps) did not show improvement from 2021 to 2023.

Element 9 Overall Review Determination was that Healthcare disparities have been reviewed and are being addressed.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 82.5 points, which results in a rating of 82.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). There is an opportunity to clarify and expand the population of members who are eligible for interventions, as well as an opportunity to address the scheduling barriers faced by working parents.

FC/WCHP PIP 2: Addressing Medicaid Members' Complaints and Grievances

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 2: Addressing Medicaid Members' Complaints and Grievances

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N**	**N**	N		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**96.9%**	**87.5%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Chris Relyea (Crelyea@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 17, 2025
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is partially compliant. For Element 2a, the AIM Statement references a 10% reduction in member balance billing grievances for the Medicaid population and needs to be updated to reflect the success in exceeding original goals. The goals expressed in the goal chart reflects the recalculated Baseline Rate of 34.11% to the updated Y2 Goal Rate of 18.61%, which is a 45% decrease. Similarly, the rates per 1000 updated Baseline of 1.82/1000 to the updated Year 2 1.03/1000, which is a 43% reduction. The August 2025 update describes the success in exceeding the original goals and clarifies changing the goals from Year 1, but this is not reflected in an updated AIM Statement.

Element 3 Overall Review Determination was that the MCO is partially compliant. For Element 3a, Section 4 (Performance Indicators), the *Numerator Definition* reads "Number of Medicaid balance billing grievances opened in the measurement period" and the *Denominator Definition* measuring "the unique members for the period". The way it is currently written indicates the number of billing grievances opened in the measurement period divided by the number of grievances and does not align with the AIM Statement. Please clarify what is being measured. Regardless, the rates of balance billing are being reduced.

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities were not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review comments provided above for future reporting. All other comments/recommendations made from IPRO have been appropriately addressed**.**

FC/WCHP PIP 3: Improving Compliance with Adolescent Immunizations specifically targeting the completion of meningococcal vaccine, Tdap vaccine, and full HPV vaccine series

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 3: Improving Compliance with Adolescent Immunizations specifically targeting the completion of meningococcal vaccine, Tdap vaccine, and full HPV vaccine series

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**0.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**0.0%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: November 10, 2025
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, it is recommended to identify the year in Table 1a in columns for Health Plan Average and Statewide Weighted Average for clarity. Also, please ensure the attestation dates are updated for future submissions.

Element 2 Overall Review Determination was N/A. Although not scored, the current objective statement requires further clarification to ensure its intent and scope are clearly understood. The objectives should be articulated with greater specificity and clear emphasis on actionable outcomes (example: Educate parent/guardians/providers about the importance of children ages 11-13 years old receiving the Tdap, Meningococcal and HPV vaccines. Identify members assigned to pilot PCP offices in the three counties Passaic, Hudson, and Bergen with no claims for Tdap, Meningococcal and HPV vaccines. Provide education about the importance of Tdap, Meningococcal and HPV vaccines at school based organizational events in the 3 targeted counties.) In Section 3, the Plan highlights specific high-risk populations, notably individuals from lower socio-economic backgrounds, minority communities, and regions with limited access to healthcare services (p. 5), as well as groups experiencing pronounced disparities, particularly low-income, minority, and uninsured populations (p. 6). Table 2a provides a racial breakdown of these disparities. It would be appropriate to incorporate a discussion of these findings within the stated goals and/or Performance Indicators to ensure alignment with the Plan's objectives.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A.

Element 5 Overall Review Determination was N/A. Although not scored, concerns were identified with aspects of Interventions and Intervention Tracking Measures. Barrier #1- Vaccine Hesitancy. For school-based organizational educational events, it is unclear if the target audience is adolescent members, their parents/guardians, or both. Intervention 1d- For tracking purposes, this should be delineated into three distinct interventions, one for each immunization. Barrier #2-Assistance with scheduling appointments-This should include tracking the number of members who attend their appointments and receive the vaccine. Although the identified barrier refers to "HPV vaccination associated with sexual activity," Intervention #2c addresses Tdap and Meningococcal vaccinations. Therefore, the barrier should be revised to encompass all three immunizations. Additionally, for more effective tracking, Intervention #2c should be divided into two separate interventions. Barrier #3- The identified barrier references only the "lack of provider-targeted messaging regarding HPV vaccination." However, interventions 3b, 3d, and 3f include metrics related to Tdap and meningococcal immunizations as well. Therefore, the barrier should be revised to reflect all three immunizations to ensure consistency and comprehensive tracking. Interventions and ITMs in Table 1b should be adjusted accordingly to match Table 1a.

Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.

Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement are not evaluated at the proposal phase.

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

Element 9 Overall Review Determination was N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with several aspects of the proposal. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2026 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

FC/WCHP PIP 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**70.0**	**65.0**	**100.0**	**90.0**
Overall Rating	**N/A**	**87.5%**	**81.3%**	**100.0%**	**90.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: October 6, 2025
Reporting Period: Year 4

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant. Indicator #1 has declined from the baseline. Similarly, Indicator #2 has decreased compared to the Year 1 baseline, and both remain below the final target. In contrast, Indicator #3 has shown an increase relative to the Year 1 baseline, yet still does not meet the final goal. Also, please note there is a discrepancy between the data reflected in Section 6, Table 2 on page 35 for Indicator #2 compared to the description noted in Section 7. In Section 7 the difference between baseline and MY1 is stated as 21.45 percentage points and should be 11.08. In addition, the difference between MY 1 and Sustainability Year is shown as 18.47 percentage points and should be 8.1 based on the data provided in Section 6, Table 2. Also, in Section 8, page 60, the second bullet under **3. System-level changes made and/or planned** has a typo (HCSB should be HCBS). Please review overall data and text for accuracy in future PIPs.

Element 9 Overall Review Determination was that Healthcare disparities have been assessed and are being addressed through identification of SDOH and appropriate referrals.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 90 points, which results in a rating of 90.0% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). Please review the comments provided above to ensure accuracy for future PIP submissions.

FC/WCHP PIP 5: Improving timely 10-day "Post-Discharge" visits from the acute care setting with assessment by the Care Manager in the MLTSS HCBS/Core Medicaid and DSNP population

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 5: Improving timely 10-day Post-Discharge visits from the acute care setting with assessment by the Care Manager in the MLTSS HCBS/Core Medicaid and DSNP population

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

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

Element 7. Discussion and Validity of Reported Improvement 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	N/A			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
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**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	N			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**0%**	**0%**	**0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/7/2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

Element 7 Overall Review Determination was that the MCO is compliant. Under Section 7, page21, “What factors were associated with success and failures?” #3b – Suggest updating “all 9,50 members” to reflect the Q2 2025 visits (9,530).

Element 8 Overall Review Determination is N/A. Sustainability is not evaluated during the interim phase.

Element 9 Overall Review Determination is "N". Evidence of healthcare disparities being identified, evaluated and/or addressed was not presented within the interim report.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). All IPRO's previous PIP review recommendations been implemented into the August report. Please make correction above in Element 7 for next submission.

FC/WCHP HEDIS Audit Review Table MY 2024

Audit Review Table					
WellCare Health Plans of New Jersey, Inc. dba Fidelis Care (Org ID: 10793, Sub ID: 11953, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2024; Date & Timestamp - 6/9/2025 4:01:49 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		90.02%	R	R	Reported
Counseling for Nutrition (Total)		84.18%	R	R	Reported
Counseling for Physical Activity (Total)		82.48%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		75.18%	R	R	Reported
IPV		88.32%	R	R	Reported
MMR		89.05%	R	R	Reported
HiB		89.54%	R	R	Reported
Hepatitis B		85.89%	R	R	Reported
VZV		87.59%	R	R	Reported
Pneumococcal Conjugate		73.72%	R	R	Reported
Hepatitis A		79.56%	R	R	Reported
Rotavirus		65.21%	R	R	Reported
Influenza		52.80%	R	R	Reported
Combo 3		65.21%	R	R	Reported
Combo 7		51.34%	R	R	Reported
Combo 10		35.28%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		90.27%	R	R	Reported
Tdap		93.67%	R	R	Reported
HPV		28.95%	R	R	Reported
Combination 1		89.29%	R	R	Reported
Combination 2		27.25%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		84.43%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		57.42%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		62.80%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		26.58%	R	R	Reported
(3-5)		61.15%	R	R	Reported
(6-14)		65.51%	R	R	Reported
(15-20)		50.26%	R	R	Reported
(Total)		55.90%	R	R	Reported
Topical Fluoride for Children (TFC)					
(1-2)		18.30%	R	R	Reported

(3-4)		27.57%	R	R	Reported
(Total)		23.05%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		66.74%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		60.00%	R	R	Reported
Bronchodilator		78.18%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		73.91%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		75.43%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		54.17%	NA	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		79.93%	R	R	Reported
Statin Adherence 80% (Total)		73.89%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.88%	R	R	Reported
Engagement1 (Total)		3.76%	R	R	Reported
Engagement2 (Total)		4.69%	R	R	Reported
Achievement (Total)		1.88%	R	R	Reported
Glycemic Status Assessment for Patients With Diabetes (GSD)					
Glycemic Status <8.0%		70.80%	R	R	Reported
Glycemic Status >9.0%		21.90%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		77.37%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		60.58%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		44.77%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		72.64%	R	R	Reported
Statin Adherence 80%		70.31%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		29.12%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Effective Acute Phase Treatment		71.09%	R	R	Reported
Effective Continuation Phase Treatment		59.40%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		50.68%	R	R	Reported
7 days (Total)		29.05%	R	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		56.45%	R	R	Reported
7 days (Total)		46.57%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.15%	R	R	Reported
Opioid (Total)		2.75%	R	R	Reported
Other (Total)		3.18%	R	R	Reported
Any (Total)		6.17%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		57.36%	R	R	Reported
7 Days (Total)		37.60%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		35.12%	R	R	Reported
7 days (Total)		24.92%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		26.89%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		77.73%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		73.89%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		86.96%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		75.77%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		81.44%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		48.32%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		78.08%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		6.05%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		12.96%	R	R	Reported
Multiple Pharmacies		1.39%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		0.52%	R	R	Reported

Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		15.50%	R	R	Reported
>=31 Days (Total)		9.47%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		82.70%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		26.49%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		4.42%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		83.70%	R	R	Reported
Postpartum Care		84.18%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		66.04%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		54.00%	R	R	Reported
(15 Months-30 Months)		78.81%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		67.63%	R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		24.22%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		59.69%	R	R	Reported
IPV		74.46%	R	R	Reported
MMR		82.46%	R	R	Reported
HiB		78.46%	R	R	Reported
Hepatitis B		61.69%	R	R	Reported
VZV		81.92%	R	R	Reported
Pneumococcal Conjugate		57.08%	R	R	Reported
Hepatitis A		73.54%	R	R	Reported
Rotavirus		51.54%	R	R	Reported
Influenza		42.15%	R	R	Reported
Combo 3		42.77%	R	R	Reported
Combo 7		33.00%	R	R	Reported
Combo 10		20.85%	R	R	Reported
Immunizations for Adolescents (IMA-E)					

Meningococcal		83.36%	R	R	Reported
Tdap		88.25%	R	R	Reported
HPV		27.54%	R	R	Reported
Combination 1		81.77%	R	R	Reported
Combination 2		25.09%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		56.50%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		52.35%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		43.31%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		43.31%	R	R	Reported
Continuation and Maintenance Phase		40.54%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		54.90%	R	R	Reported
Cholesterol Testing (Total)		40.52%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		40.52%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		3.42%	R	R	Reported
Follow-Up on Positive Screen (Total)		96.77%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		5.79%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Follow-Up PHQ-9 (Total)		10.00%	NA	R	Reported
Depression Remission (Total)		10.00%	NA	R	Reported
Depression Response (Total)		10.00%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		3.63%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (Total)		20.98%	R	R	Reported
Td/Tdap (Total)		19.94%	R	R	Reported
Zoster (Total)		10.72%	R	R	Reported
Pneumococcal (66+)		34.73%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		14.88%	R	R	Reported
Tdap		30.68%	R	R	Reported
Combination		9.79%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported

Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.23%	R	R	Reported
Follow-Up on Positive Screen		100.00%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.06%	R	R	Reported
Food Intervention (Total)		33.33%	NA	R	Reported
Housing Screening (Total)		1.70%	R	R	Reported
Housing Intervention (Total)		0.00%	NA	R	Reported
Transportation Screening (Total)		2.88%	R	R	Reported
Transportation Intervention (Total)		0.90%	R	R	Reported

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2025 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	24	6	0	24	80%
Care Management and Continuity of Care – MLTSS*	10	0	10	10	0	0	0	100%
Access**	12	0	12	10	2	0	10	83%
Emergency and Post-Stabilization Services	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	0	21	21	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	0	9	9	0	0	9	100%
Programs for the Elderly and Disabled	44	0	44	44	0	0	44	100%
Provider Training and Performance	11	0	11	11	0	0	11	100%
Satisfaction	5	0	5	5	0	0	5	100%
Enrollee Rights and Responsibilities	8	0	8	8	0	0	8	100%
Member Disenrollment	29	0	29	29	0	0	29	100%
Credentialing and Re-credentialing	10	0	10	10	0	0	10	100%
Utilization Management	30	0	30	30	0	0	30	100%
Administration and Operations	14	0	14	14	0	0	14	100%
Management Information Systems	18	0	18	18	0	0	18	100%
TOTAL	**232**	**0**	**232**	**230**	**2**	**0**	**230**	**99%**

[1] A total of 94 elements were reviewed in the previous review period; of these 94, 91 were *Met,* 3 were *Not Met*; 0 were *N/A.* Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period.

[3] 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.

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

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

**Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services.

HNJH Performance Improvement Projects

HNJH PIP 1: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 1: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**70.0**	**90.0**	**90.0**
Overall Rating	**N/A**	**100%**	**87.5%**	**90.0%**	**90.0%**

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

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 9/18/25
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant with elements 8b. Sustained improvement is only partially demonstrated, as well-child visit rates remained stable or slightly improved over time, while immunization indicators showed inconsistent performance with declines in Combo 10 completion.

Element 9 Overall Review Determination was that the MCO identified, evaluated, and addressed healthcare disparities.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 90.0 points, which results in a rating of 90.0%. Additional barrier analysis could have been warranted to identify member barriers to indicator 3, immunization combo 10, which declined since baseline and did not meet the target goal.

HNJH PIP 2: Complaints and Grievances - Core Medicaid Membership

MCO Name: Horizon New Jersey Health (HNJH)
PIP Topic 2: Complaints and Grievances - Core Medicaid Membership

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**N**	N		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Chris Relyea (crelyea@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 22, 2025
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is partially compliant. Regarding the Aim Statement section on pg. 10, the 2025 "Year 2 Measurement Period" is missing the goal rate for Indicator 3 "Decrease complaints related to top issues within Dissatisfaction with Physician Office Administration"; please update/correct for future submissions. For Element 2a, the Goal(s) chart in Section 3 and Table 2 Results in Section 6 does not accurately reflect the figures from the updated Aim Statements on page 10. (example: By the End of 2026 AIM states decrease complaints dissatisfaction with physician office admin (Ind 3) from 3.88% to 3.20%. The Goal(s) Table does not reflect this and still states 3.88%. The Section 6 Results Table 2 also states

3.88%. Please ensure the figures in each of the revised or new Aim Statements are accurately reflected in the Goals and Results tables. Also, the Objective(s) Section (pg. 4) still lists the pharmacy references, please correct in future submissions.

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant. There is a miscalculation for ITM#1a and ITM #2a, Y1, Q4, 2024. 4679/5771=81.08%, not 84.89% as reported on Table 1b. For Element 5b, the current interventions directed at providers remain passive in nature and there are no interventions targeting members. The MCO should continue to consider modifying or adding interventions related to how many Medicaid Network representatives meet with and/or discuss complaint information with providers/provider groups.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities were not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70.0 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review the calculations in Table 1b for ITM#1a and ITM #2a, Y1, Q4, 2024 (4,679/5,771) and correct going forward. Please review the comments above for consideration in future reports.

HNJH PIP 3: IMA Combo-2 PIP - Core Medicaid Membership

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 3: IMA Combo-2 PIP - Core Medicaid Membership

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M			
7d. Lessons learned & follow-up activities planned as a result	N/A	M			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org), Deb Chambers (dchambers@ipro.org)
Date reviewed: October 14, 2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. Regarding element 5d, the MCO should ensure the ITMs on Table 1a align with the ITMs on table 1b as the new ITM's are missing from Table 1a.

Element 6 Overall Review Determination was that the MCO is compliant. On Table 2 in Section 6, "Results", the Final Goal for Indicator 4 is listed as 48.03 %. Please confirm vs 48.08% as listed on the "Goals" table on pg. 17.

Element 7 Overall Review Determination was that the MCO is compliant. In Section 7, under the "Explain and interpret the results by reviewing the degree to which objectives and goals were achieved" section, please confirm meningococcal rate of 43.85% vs 43.58% (Section 3, Aim statements reports rate for meningococcal as 43.58).

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

Element 9 Overall Review Determination was that Healthcare disparities have been identified, evaluated and addressed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review the recommendations above for Elements 5, 6 and 7 and make corrections in future submissions. All IPRO's previous PIP review recommendations have been implemented into the August report. The plan is on track to meet and/or surpass the short/long-term goal rates for multiple performance indicators. If goal rates are met/surpassed through December 31, 2025, IPRO recommends establishing new goal rates that are bold, but feasible and updating the Aim Statement and Goal tables accordingly.

HNJH PIP 4: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 4: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**100.0**	**100.0**
Overall Rating	**N/A**	**90.6%**	**100.0%**	**100.0%**	**100.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/6/2025
Reporting Period: Year 4

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. Please note, there were discrepancies identified between Section 5, table 1b and Section 7 write-ups. For ITM #1a2 (SY Q2) the denominator is listed as 1,251 while in Section 7 (pg. 78) it is noted as 1,231. Also, IM #3a3 (SY Q3) and in Section 7 the calculation 6/13 should be 46.15%, not 46.45%.

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

Element 7 Overall Review Determination was that the MCO is compliant. Please note in Section 7, the table on pg. 55 related to PI4, which is an inverse measure. It seems that the color coding of green and red is correct and that the boxes for Black and Other should be "Red" and the box for White should be "Green".

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on race/ethnicity.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). Please review the comments above for future PIPs to ensure that all calculations and data provided in tables is accurate. It is commendable that sustained improvement in performance indicators was demonstrated with three of the four performance indicators meeting and surpassing their goal rates.

HNJH PIP 5: MLTSS 10-Day Post Discharge Visits with Assessment
MCO Name: Horizon NJ Health (HNJH)
PIP Topic 5: MLTSS 10-Day Post Discharge Visits with Assessment

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
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	N/A			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
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**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	Y			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**97%**	**0%**	**0%**	**0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/7/2025
Reporting Period: August Submission

IPRO Comments:

Element 1 Overall Review Determination was that the MCO is partially compliant. Please review and revise the title and/or footnote for Table 4.2, as they appear to be contradictory. The table header references the measurement year 2023, while the footnote cites preliminary baseline data from January 1, 2024, through August 31, 2024.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. Please note the calculation for ITM #2a3 for Y1Q1 2025 is stated as 13.78% and should read 13.38%.

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

Element 7 Overall Review Determination was that the MCO is compliant. Please note and update in next submission, the text on page 45 for PI1 64.93% should match the data in Section 6 and is for PI2.

Element 8 Overall Review Determination is N/A. Sustainability is not evaluated during the interim phase.

Element 9 Overall Review Determination is "Y".

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 77.5 points, which results in a rating of 97% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). All IPRO's previous PIP review recommendations have been implemented into the August report. Please review feedback in Elements 1, 5 and 7 and correct for future submissions.

HNJH HEDIS Audit Review Table MY 2024

Audit Review Table					
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health (Org ID: 6610, Sub ID: 7459, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2024; Date & Timestamp - 6/2/2025 1:35:44 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		90.83%	R	R	Reported
Counseling for Nutrition (Total)		85.83%	R	R	Reported
Counseling for Physical Activity (Total)		78.75%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		76.89%	R	R	Reported
IPV		89.54%	R	R	Reported
MMR		88.56%	R	R	Reported
HiB		90.02%	R	R	Reported
Hepatitis B		88.32%	R	R	Reported
VZV		88.81%	R	R	Reported
Pneumococcal Conjugate		73.97%	R	R	Reported
Hepatitis A		81.51%	R	R	Reported
Rotavirus		70.80%	R	R	Reported
Influenza		50.85%	R	R	Reported
Combo 3		68.61%	R	R	Reported
Combo 7		56.45%	R	R	Reported
Combo 10		36.50%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		92.70%	R	R	Reported
Tdap		94.65%	R	R	Reported
HPV		35.77%	R	R	Reported
Combination 1		92.46%	R	R	Reported
Combination 2		35.52%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		80.90%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		60.80%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		61.80%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		26.93%	R	R	Reported
(3-5)		61.71%	R	R	Reported
(6-14)		67.07%	R	R	Reported
(15-20)		51.89%	R	R	Reported
(Total)		57.77%	R	R	Reported
Topical Fluoride for Children (TFC)					
(1-2)		16.38%	R	R	Reported

(3-4)		26.12%	R	R	Reported
(Total)		21.43%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		68.26%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		74.78%	R	R	Reported
Bronchodilator		90.82%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		82.34%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		69.85%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		66.33%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		84.02%	R	R	Reported
Statin Adherence 80% (Total)		76.73%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.67%	R	R	Reported
Engagement1 (Total)		4.09%	R	R	Reported
Engagement2 (Total)		4.58%	R	R	Reported
Achievement (Total)		1.87%	R	R	Reported
Glycemic Status Assessment for Patients With Diabetes (GSD)					
Glycemic Status <8.0%		56.03%	R	R	Reported
Glycemic Status >9.0%		32.16%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		74.62%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		61.31%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		48.53%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		72.26%	R	R	Reported
Statin Adherence 80%		70.02%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		27.70%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Effective Acute Phase Treatment		60.87%	R	R	Reported
Effective Continuation Phase Treatment		46.52%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		57.71%	R	R	Reported
7 days (Total)		30.63%	R	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		64.99%	R	R	Reported
7 days (Total)		55.16%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.73%	R	R	Reported
Opioid (Total)		3.76%	R	R	Reported
Other (Total)		3.72%	R	R	Reported
Any (Total)		7.46%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		54.10%	R	R	Reported
7 Days (Total)		30.97%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		44.74%	R	R	Reported
7 days (Total)		33.45%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		25.62%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		88.52%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		74.95%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		79.81%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		72.55%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		84.04%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		51.61%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		71.96%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.33%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		18.75%	R	R	Reported
Multiple Pharmacies		1.83%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.02%	R	R	Reported

Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		5.93%	R	R	Reported
>=31 Days (Total)		3.68%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		81.52%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		42.74%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		17.95%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		88.65%	R	R	Reported
Postpartum Care		83.84%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		73.10%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		59.06%	R	R	Reported
(15 Months-30 Months)		77.89%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		66.57%	R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		27.77%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		68.34%	R	R	Reported
IPV		81.35%	R	R	Reported
MMR		86.03%	R	R	Reported
HiB		83.91%	R	R	Reported
Hepatitis B		77.28%	R	R	Reported
VZV		85.69%	R	R	Reported
Pneumococcal Conjugate		64.97%	R	R	Reported
Hepatitis A		78.54%	R	R	Reported
Rotavirus		64.25%	R	R	Reported
Influenza		46.47%	R	R	Reported
Combo 3		55.71%	R	R	Reported
Combo 7		45.97%	R	R	Reported
Combo 10		28.86%	R	R	Reported
Immunizations for Adolescents (IMA-E)					

Meningococcal		88.74%	R	R	Reported
Tdap		91.03%	R	R	Reported
HPV		34.11%	R	R	Reported
Combination 1		87.90%	R	R	Reported
Combination 2		32.76%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		59.50%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		56.49%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		46.39%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		34.18%	R	R	Reported
Continuation and Maintenance Phase		38.50%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		59.94%	R	R	Reported
Cholesterol Testing (Total)		41.41%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		40.72%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.06%	R	R	Reported
Follow-Up on Positive Screen (Total)		51.67%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.30%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Follow-Up PHQ-9 (Total)		7.32%	R	R	Reported
Depression Remission (Total)		0.00%	R	R	Reported
Depression Response (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (Total)		16.16%	R	R	Reported
Td/Tdap (Total)		34.96%	R	R	Reported
Zoster (Total)		13.42%	R	R	Reported
Pneumococcal (66+)		54.67%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		18.94%	R	R	Reported
Tdap		42.03%	R	R	Reported
Combination		13.57%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported

Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.00%	R	R	Reported
Food Intervention (Total)			NA	R	Reported
Housing Screening (Total)		0.00%	R	R	Reported
Housing Intervention (Total)			NA	R	Reported
Transportation Screening (Total)		0.00%	R	R	Reported
Transportation Intervention (Total)			NA	R	Reported

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2025 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	26	4	0	26	87%
Care Management and Continuity of Care – MLTSS*	10	0	10	10	0	0	0	100%
Access**	12	0	12	9	3	0	9	75%
Emergency and Post-Stabilization Services	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	0	21	20	1	0	20	95%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	0	9	9	0	0	9	100%
Programs for the Elderly and Disabled	44	0	44	44	0	0	44	100%
Provider Training and Performance	11	0	11	11	0	0	11	100%
Satisfaction	5	0	5	5	0	0	5	100%
Enrollee Rights and Responsibilities	8	0	8	7	1	0	7	88%
Member Disenrollment	29	0	29	27	2	0	27	93%
Credentialing and Re-credentialing	10	0	10	10	0	0	10	100%
Utilization Management	30	0	30	28	0	2	28	100%
Administration and Operations	14	0	14	14	0	0	14	100%
Management Information Systems	18	0	18	18	0	0	18	100%
TOTAL	**232**	**0**	**232**	**223**	**7**	**2**	**223**	**97%**

[1] A total of 91 elements were reviewed in the previous review period; of these 91, 85 were *Met,* 4 were *Not Met*; 2 were *N/A.* Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period.

[3] 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.

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

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

**Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services.

UHCCP Performance Improvement Projects

UHCCP PIP 1: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 1: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**80.0**	**82.5**	**82.5**
Overall Rating	**N/A**	**100.0%**	**100.0%**	**82.5%**	**82.5%**

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

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 9/18/25
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant with Element 5a. Per Year 3 comments, provider barriers were identified but not leveraged to inform modifications to interventions, limiting the extent to which barrier analysis guided intervention design and sustainability. Given that Practice 1 demonstrated lower rates compared to other practices, interventions specifically aimed at addressing Practice 1 barriers should have been considered.

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant with Element 8b. Only one of the three performance indicators, (CIS combo 10) showed improvement for the combined rate.

Element 9 Overall Review Determination was that the MCO identified health care disparities and is prioritizing interventions based on the analysis.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 82.5 points, which results in a rating of 82.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). Provider barriers were identified but not leveraged to inform modifications to interventions, limiting the extent to which barrier analysis guided intervention design and sustainability.

UHCCP PIP 2: Reducing Member Grievances for Medicaid Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 2: Reducing Member Grievances for Medicaid Members

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**N**	N		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**80.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**100.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Chris Relyea (crelyea@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) Reviewed: November 14, 2025
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. The MCO should consider tracking how many providers are receiving cease and desist letters by quarter in order to determine how significant this issue is and to develop a threshold benchmark to determine when additional actions are required to manage providers with repeated cease and desist letters.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities were not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 80.0 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant changes over this past year, taking time to review every aspect of the PIP, using the QI process to make appropriate changes in each area when needed. Please review the feedback provided in Element 5 for consideration in future submissions. Please note, there is an error in the Reporting Schedule and Forms table. The Final Report is currently listed as August 2026 and should be August 2027. Please kindly correct in future submissions.

UHCCP PIP 3: Immunizations for Adolescents (IMA)

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 3: Immunizations for Adolescents (IMA)

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M			
7d. Lessons learned & follow-up activities planned as a result	N/A	M			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**96.9%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Jeffrey Worden, MPH (Jworden@ipro.org), Deb Chambers (dchambers@ipro.org)
Date reviewed: October 14, 2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

Element 6 Overall Review Determination was that the MCO is partially compliant. For Element 6a, preliminary data should be presented for the August 2025 submission (ex. Jan-Jun 2025), with finalized data for the 2025 measurement year presented once available. Also, please update the RY heading in the Section 6, Table 2 MY2 2026 column for future submissions.

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

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

Element 9 Overall Review Determination was that Healthcare disparities have been identified, evaluated and addressed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 77.5 points, which results in a rating of 96.9% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review comments above related to Element 6a (presenting preliminary results). All other IPRO previous PIP review recommendations have been implemented into the August report.

UHCCP PIP 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**77.5**	**100.0**	**90.0**
Overall Rating	**N/A**	**81.3%**	**96.9%**	**100.0%**	**90.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/6/2025
Reporting Period: Year 4

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant. Indicator #1 has declined relative to the baseline and remains below the final target, whereas Indicator #2 has increased and exceeded the established goal.

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on social determinants of health.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 90 points, which results in a rating of 90.0% (Which is above 86% [≥ 86% being the threshold for meeting compliance]).

UHCCP PIP 5: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 5: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

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

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

Element 7. Discussion and Validity of Reported Improvement 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	N/A			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
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**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	N			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**0%**	**0%**	**0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/7/2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination is N/A. Sustainability is not evaluated during the interim phase.

Element 9 Overall Review Determination is "N". At this time, the plan has not evaluated, identified, and/or proposed an intervention targeted to improve performance indicator rates for any specific disparity group.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). All IPRO's previous PIP review recommendations have been implemented into the August report.

UHCCP HEDIS Audit Review Table MY 2024

Audit Review Table					
AmeriChoice of New Jersey, Inc. (UnitedHealthcare Community Plan (NJ)) (Org ID: 1995, Sub ID: 8004, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2024; Date & Timestamp - 6/10/2025 8:30:56 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		89.29%	R	R	Reported
Counseling for Nutrition (Total)		81.75%	R	R	Reported
Counseling for Physical Activity (Total)		79.81%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		71.78%	R	R	Reported
IPV		83.21%	R	R	Reported
MMR		81.27%	R	R	Reported
HiB		83.21%	R	R	Reported
Hepatitis B		81.27%	R	R	Reported
VZV		81.27%	R	R	Reported
Pneumococcal Conjugate		66.18%	R	R	Reported
Hepatitis A		67.64%	R	R	Reported
Rotavirus		63.02%	R	R	Reported
Influenza		43.31%	R	R	Reported
Combo 3		59.85%	R	R	Reported
Combo 7		45.26%	R	R	Reported
Combo 10		29.93%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		89.05%	R	R	Reported
Tdap		92.70%	R	R	Reported
HPV		33.33%	R	R	Reported
Combination 1		88.56%	R	R	Reported
Combination 2		31.87%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		77.13%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		59.85%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		64.18%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		22.43%	R	R	Reported
(3-5)		60.16%	R	R	Reported
(6-14)		67.35%	R	R	Reported
(15-20)		54.05%	R	R	Reported
(Total)		58.16%	R	R	Reported
Topical Fluoride for Children (TFC)					
(1-2)		17.63%	R	R	Reported

(3-4)		30.54%	R	R	Reported
(Total)		24.07%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		78.07%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		61.74%	R	R	Reported
Bronchodilator		85.09%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		56.96%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		74.21%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		58.49%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		82.39%	R	R	Reported
Statin Adherence 80% (Total)		79.24%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.24%	R	R	Reported
Engagement1 (Total)		2.33%	R	R	Reported
Engagement2 (Total)		3.27%	R	R	Reported
Achievement (Total)		1.09%	R	R	Reported
Glycemic Status Assessment for Patients With Diabetes (GSD)					
Glycemic Status <8.0%		68.61%	R	R	Reported
Glycemic Status >9.0%		22.87%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		73.24%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		62.76%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		50.87%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		73.17%	R	R	Reported
Statin Adherence 80%		75.42%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		27.56%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Effective Acute Phase Treatment		66.75%	R	R	Reported
Effective Continuation Phase Treatment		49.88%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		52.62%	R	R	Reported
7 days (Total)		30.98%	R	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		61.09%	R	R	Reported
7 days (Total)		48.84%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.25%	R	R	Reported
Opioid (Total)		3.03%	R	R	Reported
Other (Total)		3.28%	R	R	Reported
Any (Total)		6.25%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		45.09%	R	R	Reported
7 Days (Total)		24.39%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		43.24%	R	R	Reported
7 days (Total)		31.41%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		20.45%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		88.13%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		80.31%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		89.17%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		73.77%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		81.92%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		50.13%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		74.10%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		8.80%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		11.82%	R	R	Reported
Multiple Pharmacies		1.43%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		0.79%	R	R	Reported

Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		7.85%	R	R	Reported
>=31 Days (Total)		4.64%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		85.36%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		42.94%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		13.84%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		84.91%	R	R	Reported
Postpartum Care		85.89%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		68.11%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		56.67%	R	R	Reported
(15 Months-30 Months)		75.97%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		65.22%	R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		28.06%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		60.86%	R	R	Reported
IPV		73.44%	R	R	Reported
MMR		79.41%	R	R	Reported
HiB		74.91%	R	R	Reported
Hepatitis B		56.55%	R	R	Reported
VZV		79.17%	R	R	Reported
Pneumococcal Conjugate		57.73%	R	R	Reported
Hepatitis A		67.13%	R	R	Reported
Rotavirus		53.87%	R	R	Reported
Influenza		39.56%	R	R	Reported
Combo 3		41.87%	R	R	Reported
Combo 7		34.00%	R	R	Reported
Combo 10		24.43%	R	R	Reported
Immunizations for Adolescents (IMA-E)					

Meningococcal		84.81%	R	R	Reported
Tdap		88.12%	R	R	Reported
HPV		28.41%	R	R	Reported
Combination 1		83.60%	R	R	Reported
Combination 2		26.86%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		65.12%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		57.71%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		52.90%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		42.21%	R	R	Reported
Continuation and Maintenance Phase		47.26%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		61.02%	R	R	Reported
Cholesterol Testing (Total)		44.08%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		42.73%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		1.30%	R	R	Reported
Follow-Up on Positive Screen (Total)		66.67%	NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.01%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Follow-Up PHQ-9 (Total)		0.00%	NA	R	Reported
Depression Remission (Total)		0.00%	NA	R	Reported
Depression Response (Total)		0.00%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.34%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (Total)		14.65%	R	R	Reported
Td/Tdap (Total)		28.21%	R	R	Reported
Zoster (Total)		12.73%	R	R	Reported
Pneumococcal (66+)		41.56%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		14.84%	R	R	Reported
Tdap		33.90%	R	R	Reported
Combination		10.08%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		3.29%	R	R	Reported
Follow-Up on Positive Screen		50.00%	NA	R	Reported

Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		1.89%	R	R	Reported
Follow-Up on Positive Screen		50.00%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.32%	R	R	Reported
Food Intervention (Total)		4.81%	R	R	Reported
Housing Screening (Total)		0.18%	R	R	Reported
Housing Intervention (Total)		0.00%	R	R	Reported
Transportation Screening (Total)		0.26%	R	R	Reported
Transportation Intervention (Total)		0.00%	R	R	Reported

WPNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

WPNJ 2025 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	27	3	0	27	90%
Care Management and Continuity of Care – MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	0	12	11	1	0	11	92%
Emergency and Post-Stabilization Services	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	0	21	21	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	0	9	9	0	0	9	100%
Programs for the Elderly and Disabled	44	0	44	44	0	0	44	100%
Provider Training and Performance	11	0	11	11	0	0	11	100%
Satisfaction	5	0	5	5	0	0	5	100%
Enrollee Rights and Responsibilities	8	0	8	8	0	0	8	100%
Member Disenrollment	29	0	29	29	0	0	29	100%
Credentialing and Re-credentialing	10	0	10	9	1	0	9	90%
Utilization Management	30	0	30	30	0	0	30	100%
Administration and Operations	14	0	14	14	0	0	14	100%
Management Information Systems	18	0	18	18	0	0	18	100%
TOTAL	**232**	**0**	**232**	**230**	**2**	**0**	**230**	**99%**

[1] A total of 94 elements were reviewed in the previous review period; of these 94, 87 were *Met,* 7 were *Not Met*; 0 were *N/A.* Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

[2] 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.

[3] 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.

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

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

**Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services.

WPNJ Performance Improvement Projects

WPNJ PIP 1: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 1: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**67.5**	**70.0**	**92.5**	**92.5**
Overall Rating	**N/A**	**84.4%**	**87.5%**	**92.5%**	**92.5%**

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

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 9/18/25
Reporting Period: Final Report

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

Element 4 Overall Review Determination was that the MCO is partially compliant with elements 4b. It is unclear whether the Plan obtained direct member feedback on barriers, as the analysis appears to rely primarily on literature review and provider input. The Plan should have conducted direct outreach to members to better understand their specific barriers to completing well-child visits and immunizations.

Element 5 Overall Review Determination was that the MCO is compliant.

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that the MCO identified, evaluated, and addressed healthcare disparities.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 92.5 points, which results in a rating of 92.5%.

WPNJ PIP 2: Decreasing Member Grievances Related to Balance Billing Issues

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 2: Decreasing Member Grievances Related to Balance Billing Issues

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**M**		
Element 7 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**N**	N		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**70.0**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**87.5%**	**90.6%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Chris Relyea (crelyea@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 23, 2025
Reporting Period: Year 2 Findings

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant. For Element 5b, the new ITM 5b states that it is measuring dual covered members who filed a "member grievance", not focusing on filing a member balance billing grievance, which is the focus of the PIP. It would be more relevant to focus on dual members who filed a balance billing grievance.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities were not identified, evaluated, or addressed.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review comments above for future reporting.
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WPNJ PIP 3: Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 3: Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance

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

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

Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M			
7d. Lessons learned & follow-up activities planned as a result	N/A	M			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: Element 9. Healthcare Disparities					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**0.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Jeffrey Worden, MPH (Jworden@ipro.org), Deb Chambers (dchambers@ipro.org)
Date reviewed: October 14, 2025
Reporting Period: Year 1

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant.

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

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

Element 5 Overall Review Determination was that the MCO is compliant.

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

Element 7 Overall Review Determination was that the MCO is compliant.
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Element 8 Overall Review Determination is N/A. Sustainability is not evaluated at the Year 1 phase.

Element 9 Overall Review Determination was that Healthcare disparities have been identified, evaluated and addressed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). In future submissions the MCO should be aware of the following: Section 6, Table 2, the description of footer 2 is missing and should be updated. For ITM #2a (2592/2754) the rate is listed as 95.12% and should be 94.12%. Also, the MCO should ensure that Appendix C Submission Date column is completed. For ITM #4b: "Percentage of parents/guardians of adolescents that viewed social media postings regarding the new online Appointment Assistance Request feature on the member website," it is unclear how the MCO will determine the number of parents/guardians who "viewed social media postings regarding the new online Appointment Assistance Request feature on the member website". The MCO acknowledges this limitation under the "Were there any threats to the external validity of the findings?" section on page 30, so the accuracy of this ITM measure is questionable. All of IPRO's previous PIP review recommendations have been implemented into the August report.

WPNJ PIP 4: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 4: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**92.5**	**100.0**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**92.5%**	**100.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Evelyn Rowell (erowell@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/6/2025
Reporting Period: Year 4

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant. Please note, it is unclear whether the date for change 25 is an anticipated or incorrect date. Please ensure all data for accuracy in future PIP submissions.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. There are 2 data errors on page 34. In the section for Interventions 3a and 3b the total number members unable to reach is listed as 4, however the Q1-Q4 numbers is 5. Also, for Intervention 4a, it is stated that 16 members were unable to be reached, however in table 1b the denominator for Q1-Q4 is 66 and of those only 20 members were reached leaving 46 unable to reach. Please clarify where the data for Q1-Q4 was gathered and please check all data and text for accuracy in future PIP submissions.

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that the MCO is implementing processes to evaluate healthcare disparities.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100.0% (Which is ≥ the 86% threshold for meeting compliance). Please review the comments provided above to ensure accuracy for future PIP submissions. Although Indicator #1 and #2 continue to fall short of the final target, they have both demonstrated improvement over the course of the project.

WPNJ PIP 5: Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 5: Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members

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

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

Element 7. Discussion and Validity of Reported Improvement 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	N/A			
Element 7 Overall Review Determination	**N/A**	**M**			
Element 7 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**0.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
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**			
Element 8 Overall Score	**N/A**	**N/A**	**0**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**0.0**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**Y**			

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100%**	**0%**	**0%**	**0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Jeffrey Worden, MPH (jworden@ipro.org); Karen Halley (khalley@ipro.org)
Date (report submission) reviewed: 10/7/2025
Reporting Period: August Submission

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is compliant.

Element 2 Overall Review Determination was that the MCO is compliant. IPRO recommends replacing the language "within 10 days" to "within 10 business days" throughout the PIP.

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

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

Element 5 Overall Review Determination was that the MCO is compliant. For ITM #4a, IPRO recommends revising the numerator definition to clarify that the ITM is tracking whether the Care Manager (not the member) received a timely (3 business days) discharge notification through SharePoint.

Element 6 Overall Review Determination was that the MCO is compliant. In Section 6, Table 2, PI#2 calculation for Baseline rate is shown as 62.83% and should read 62.80. This is also carried over to Section 7 explanation. Similarly, the PI#3 Ya 2025 calculation in Table 2 is reflected as 9.62% and should read 8.77. This is also carried over to the Section 7 explanation.

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

Element 8 Overall Review Determination is N/A. Sustainability is not evaluated during the interim phase.

Element 9 Overall Review Determination is "Y". The plan initially identified that the largest volume in hospitalizations were in Passaic and Bergen counties. The plan stated they will conduct further analysis to determine opportunities to address the disparity at the county level. At this time, the plan has not proposed disparity specific intervention tracking measure(s).

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). All IPRO's previous PIP review recommendations have been implemented into the August report. Please review the feedback above and make corrections, as appropriate, in future submissions.

WPNJ HEDIS Audit Review Table MY 2024

Audit Review Table					
Wellpoint New Jersey, Inc. (Org ID: 1791, Sub ID: 4308, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2024; Date & Timestamp - 6/11/2025 2:38:29 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		89.78%	R	R	Reported
Counseling for Nutrition (Total)		84.43%	R	R	Reported
Counseling for Physical Activity (Total)		83.21%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		70.80%	R	R	Reported
IPV		84.43%	R	R	Reported
MMR		84.67%	R	R	Reported
HiB		84.67%	R	R	Reported
Hepatitis B		83.45%	R	R	Reported
VZV		85.64%	R	R	Reported
Pneumococcal Conjugate		69.83%	R	R	Reported
Hepatitis A		75.91%	R	R	Reported
Rotavirus		60.10%	R	R	Reported
Influenza		41.61%	R	R	Reported
Combo 3		63.75%	R	R	Reported
Combo 7		49.15%	R	R	Reported
Combo 10		30.41%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		89.54%	R	R	Reported
Tdap		94.16%	R	R	Reported
HPV		28.71%	R	R	Reported
Combination 1		89.29%	R	R	Reported
Combination 2		27.49%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		82.48%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		64.48%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		61.10%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		17.77%	R	R	Reported
(3-5)		58.43%	R	R	Reported
(6-14)		65.64%	R	R	Reported
(15-20)		48.88%	R	R	Reported
(Total)		53.77%	R	R	Reported
Topical Fluoride for Children (TFC)					
(1-2)		17.33%	R	R	Reported

(3-4)		22.73%	R	R	Reported
(Total)		20.07%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		85.38%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		74.01%	R	R	Reported
Bronchodilator		88.11%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		61.60%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		69.59%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		64.00%	NA	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		83.14%	R	R	Reported
Statin Adherence 80% (Total)		73.10%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.17%	R	R	Reported
Engagement1 (Total)		3.89%	R	R	Reported
Engagement2 (Total)		5.45%	R	R	Reported
Achievement (Total)		2.72%	R	R	Reported
Glycemic Status Assessment for Patients With Diabetes (GSD)					
Glycemic Status <8.0%		65.69%	R	R	Reported
Glycemic Status >9.0%		28.22%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		70.56%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		50.09%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		47.12%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		73.76%	R	R	Reported
Statin Adherence 80%		67.05%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		23.20%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Effective Acute Phase Treatment		63.12%	R	R	Reported
Effective Continuation Phase Treatment		46.71%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		47.03%	R	R	Reported
7 days (Total)		26.98%	R	R	Reported

Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		58.39%	R	R	Reported
7 days (Total)		48.00%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.14%	R	R	Reported
Opioid (Total)		2.89%	R	R	Reported
Other (Total)		3.16%	R	R	Reported
Any (Total)		5.91%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		52.69%	R	R	Reported
7 Days (Total)		27.51%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		42.45%	R	R	Reported
7 days (Total)		29.28%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		22.85%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		86.49%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		82.80%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		90.54%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		77.30%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		86.30%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		56.80%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		73.49%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		8.16%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		13.97%	R	R	Reported
Multiple Pharmacies		2.17%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.10%	R	R	Reported

Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		6.21%	R	R	Reported
>=31 Days (Total)		4.26%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		80.67%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		53.39%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		25.22%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		90.75%	R	R	Reported
Postpartum Care		87.59%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		56.99%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		58.07%	R	R	Reported
(15 Months-30 Months)		79.61%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		67.34%	R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		29.06%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		66.08%	R	R	Reported
IPV		80.16%	R	R	Reported
MMR		84.39%	R	R	Reported
HiB		82.95%	R	R	Reported
Hepatitis B		74.18%	R	R	Reported
VZV		83.83%	R	R	Reported
Pneumococcal Conjugate		63.86%	R	R	Reported
Hepatitis A		71.62%	R	R	Reported
Rotavirus		56.93%	R	R	Reported
Influenza		38.72%	R	R	Reported
Combo 3		53.24%	R	R	Reported
Combo 7		39.25%	R	R	Reported
Combo 10		22.99%	R	R	Reported
Immunizations for Adolescents (IMA-E)					

Meningococcal		86.95%	R	R	Reported
Tdap		90.03%	R	R	Reported
HPV		27.03%	R	R	Reported
Combination 1		85.75%	R	R	Reported
Combination 2		25.39%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		58.62%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		59.20%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		42.00%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		37.75%	R	R	Reported
Continuation and Maintenance Phase		47.32%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		62.75%	R	R	Reported
Cholesterol Testing (Total)		48.64%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		47.20%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		3.96%	R	R	Reported
Follow-Up on Positive Screen (Total)		58.33%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		3.13%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Follow-Up PHQ-9 (Total)		15.38%	NA	R	Reported
Depression Remission (Total)		15.38%	NA	R	Reported
Depression Response (Total)		15.38%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.37%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (Total)		18.36%	R	R	Reported
Td/Tdap (Total)		27.36%	R	R	Reported
Zoster (Total)		8.10%	R	R	Reported
Pneumococcal (66+)		46.53%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		13.69%	R	R	Reported
Tdap		29.24%	R	R	Reported
Combination		8.73%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		7.97%	R	R	Reported
Follow-Up on Positive Screen		50.00%	NA	R	Reported

Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		11.48%	R	R	Reported
Follow-Up on Positive Screen		45.45%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		6.16%	R	R	Reported
Food Intervention (Total)		6.21%	R	R	Reported
Housing Screening (Total)		4.26%	R	R	Reported
Housing Intervention (Total)		0.14%	R	R	Reported
Transportation Screening (Total)		4.33%	R	R	Reported
Transportation Intervention (Total)		0.00%	R	R	Reported

Appendix B – ABHNJ 2025 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Aetna Better Health of New Jersey

Review Period: January 1, 2024 to December 31, 2024

September 2025

Corporate Headquarters
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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

MCO Care Management Chart Audit

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a

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

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant Enrollees from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 369 cases for Aetna Better Health of New Jersey (ABHNJ).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees (including a 30% oversample required for substitutions or exclusions) was selected for the General, DDD, and DCP&P Populations. If the MCO's sample did not meet the sample size of 130 for each individual population, the entire population was selected.

ABHNJ's initial submission of the DDD Enrollee sample file successfully met the established sampling criteria. However, upon further review, it was determined that the submission did not comply with the specification criteria for exclusions. As a result, ABHNJ was required to resubmit an additional 46 DDD Enrollee files to ensure proper adherence to the exclusion guidelines and to facilitate a complete review, resulting in a total of 415 cases for ABHNJ.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible new and existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL).	Capitation Codes 17399, 37399, 57599, 59199, 87399, and 99499.	Capitation Codes 49499 or 81299 ***OR*** PSC 600 and County Code less than 22. ***AND*** (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499).
	IPRO will pull a random sample from the universes provided as follows:	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for:	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for:
	1) 65 Enrollees new to the MCO and Care Management anytime	1) ALL newly eligible DDD Enrollees in Care Management	1) ALL newly eligible DCP&P Enrollees in Care Management

	from 1/1/2024 through 11/16/2024 ***AND*** 2) 65 existing Enrollees new to Care Management from 3/1/2024 through 11/16/2024 from the universes provided.* * Random sample size modified by IPRO.	***AND*** 2) ALL existing eligible DDD Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.* * Random sample size modified by IPRO.	***AND*** 2) ALL existing eligible DCP&P Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.* * Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2024	>= 6 months as of 12/31/2024	>= 6 months and < 18 years as of 12/31/2024
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024
• Existing Enrollees	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024
Current Enrollment	Enrolled as of 12/31/2024 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2024 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.

Introductory E-Mail

For this year's chart audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year's audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's secure S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted file reviews over a five-week period. Inter-rater reliability was maintained through the use of a standardized Audit Tool, along with ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite chart audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's 2025 CM Audit results for the review period 1/01/2024 to 12/31/2024 ranged from 27.8% to 100.0% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=74)
Identification[1]	67.6%		
Outreach[2,3]	86.0%	100.0%	91.7%
Preventive Services[3]	84.3%	27.8%	58.5%
Continuity of Care[3]	96.9%	61.7%	86.3%
Coordination of Services[3]	93.3%	59.6%	96.5%

[1]The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of new and existing population specific rates.

General Population Findings

A combined total of 128 files were reviewed for the new and existing General Population. There were 28 files excluded from the analysis due to TPL or they did not meet the Care Management enrollment criteria for the review period. The remaining 100 files were assessed for compliance across the following five categories.

Identification

The Identification category applies to GP Enrollees (49) new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024. The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.

Table 3: Identification – General Population - Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2024 to 12/31/2024).*	48	49	98.0%
IHS was completed for the Enrollee within 45 days of MCO enrollment date.*	37	48	77.1%
For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date.	0	12	0.0%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	25	25	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (49) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (51) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	49	49	100.0%	50	51	98.0%
MCO completed the CNA timely (within 30 days from IHS score of 5 or greater, or from date of identification of CM needs).*	42	49	85.7%	43	50	86.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs.[1]	6	7	85.7%	7	8	87.5%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	10	11	90.9%	14	17	82.4%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 7 files with untimely CNAs for new GP Enrollees; and 7 files with untimely CNAs and 1 file without a CNA for existing GP Enrollees.

Preventive Services

The Preventive Services category applies to new GP Enrollees (49) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (51) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 5: Preventive Services – General Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	14	14	100.0%	16	17	94.1%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	1	1	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	1	0.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	13	13	100.0%	14	17	82.4%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	0	0	N/A	2	3	66.7%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	28	32	87.5%	24	26	92.3%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	0	4	0.0%	1	2	50.0%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	35	35	100.0%	33	34	97.1%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	5	11	45.5%	11	16	68.8%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	5	6	83.3%	5	5	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	3	6	50.0%	1	5	20.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (49) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (51) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	49	49	100.0%	50	51	98.0%
CNA was completed timely (within 30 days of identification of CM needs).	42	49	85.7%	43	50	86.0%
CNA contained all elements of the State approved CNA tool.	49	49	100.0%	50	50	100.0%
Care Manager documented a level of care for the Enrollee during the review period.	49	49	100.0%	50	50	100.0%

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee had a Care Plan on file during the review period.	49	49	100.0%	51	51	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	45	49	91.8%	47	50	94.0%
Care Plan was completed for the Enrollee that included all required components.	49	49	100.0%	51	51	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	49	49	100.0%	51	51	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	5	5	100.0%	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	1	2	50.0%	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (49) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (51) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	2	2	100.0%	7	7	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	34	34	100.0%	34	35	97.1%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	5	5	100.0%	5	5	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	3	8	37.5%	7	8	87.5%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

A combined total of 173 files were reviewed for the new and existing DDD Population. There were 73 files excluded from the analysis due to TPL or they did not meet the Care Management enrollment criteria for the review period. The remaining 100 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DDD Enrollees (16) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	7	16	43.8%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	6	7	85.7%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	10	10	100.0%

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 1 file with an untimely CNA and 9 files without a CNA.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (16) and existing DDD Enrollees (84) in Care Management during the 2024 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	0	5	0.0%	11	30	36.7%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	4	5	80.0%	7	19	36.8%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	5	0.0%	0	19	0.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	2	5	40.0%	6	26	23.1%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	3	100.0%	2	20	10.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	2	9	22.2%	13	56	23.2%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	5	7	71.4%	9	43	20.9%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	3	11	27.3%	17	54	31.5%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	0	5	0.0%	11	30	36.7%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	4	5	80.0%	5	19	26.3%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	1	5	20.0%	5	19	26.3%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (16) and existing DDD Enrollees (84) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	7	16	43.8%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	6	7	85.7%			
CNA contained all elements of the State approved CNA tool.	7	7	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	7	7	100.0%	41	84	48.8%
The Enrollee had a Care Plan on file during the review period.	16	16	100.0%	23	84	27.4%
Care Plan was developed within 30 days of CNA completion.[1]	5	7	71.4%			
Care Plan was completed for the Enrollee that included all required components.	14	16	87.5%	21	23	91.3%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	16	16	100.0%	23	23	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	0	0	N/A	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (16) and existing DDD Enrollees (84) in Care Management during the 2024 review period.

Table 11: Coordination of Services – DDD Population - New and Existing Enrollees in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	13	16	81.2%	38	84	45.2%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	6	6	100.0%	11	12	91.7%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	2	2	100.0%	4	4	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	3	3	100.0%	4	9	44.4%
For Enrollees hospitalized with a mental/behavioral health diagnosis, the Care Manager made aggressive outreach attempts to determine follow-up status with a mental/behavioral health provider.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

A combined total of 109 files were reviewed for the new and existing DCP&P Population. There were 35 files excluded from the analysis due to adoption, adoption subsidy, interstate services, reunification with a parent, TPL, and they did not meet the Care Management enrollment criteria during the review period. The remaining 74 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DCP&P Enrollees (19) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population - Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	16	19	84.2%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	7	16	43.8%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	11	12	91.7%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 9 files with untimely CNAs and 3 files without a CNA.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (19) and existing DCP&P Enrollees (55) in Care Management during the 2024 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	17	19	89.5%	53	55	96.4%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	2	50.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	2	0.0%	0	2	0.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	15	19	78.9%	48	53	90.6%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	4	75.0%	3	5	60.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	11	12	91.7%	40	51	78.4%
Appropriate outreach attempts were documented to confirm dental status for	0	1	0.0%	9	11	81.8%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollees without a confirmed dental visit (aged 1 through 20).						
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	0	1	0.0%	6	11	54.5%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations.

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (19) and existing DCP&P Enrollees (55) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	16	19	84.2%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	7	16	43.8%			
CNA contained all elements of the State approved CNA tool.	16	16	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	16	16	100.0%	49	55	89.1%
The Enrollee had a Care Plan on file during the review period.	16	19	84.2%	34	55	61.8%
Care Plan was developed within 30 days of CNA completion.[1]	15	16	93.8%			
Care Plan was completed for the Enrollee that included all required components.	16	16	100.0%	34	34	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	16	16	100.0%	34	34	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	0	0	N/A	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (19) and existing DCP&P Enrollees (55) in Care Management during the 2024 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	19	19	100.0%	55	55	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	1	1	100.0%	2	3	66.7%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	1	1	100.0%	1	1	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	3	5	60.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

Limitations

ABHNJ's file universe included only 109 DCP&P Enrollees, which did not meet the required sample size of 130. Rates with a denominator of less than 30 are not statistically significant and should be considered cautiously.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (86.0%)
- Outreach (DDD Population) (100.0%)
- Outreach (DCP&P Population) (91.7%)

- Continuity of Care (General Population) (96.9%)
- Continuity of Care (DCP&P Population) (86.3%)

- Coordination of Services (General Population) (93.3%)
- Coordination of Services (DCP&P Population) (96.5%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (67.6%)

- Preventive Services (General Population) (84.3%)
- Preventive Services (DDD Population) (27.8%)
- Preventive Services (DCP&P Population) (58.5%)

- Continuity of Care (DDD Population) (61.7%)

- Coordination of Services (DDD Population) (59.6%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Aetna Better Health of New Jersey (ABHNJ), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key ABHNJ staff via TEAMS held on July 16, 2025, and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 7, 2025, and submissions were received from the MCOs on April 4, 2025. The documentation review occurred offsite at IPRO beginning on April 7, 2025. The audit review team was made up of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2024 to December 31, 2024.

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

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A – Not Applicable	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. ABHNJ received an overall compliance score of 73% in 2025. In 2024, the MCO received a score of 77%. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Where appropriate, assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2024 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of ABHNJ's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	X	X	-	-	-	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	X	-	X	-	-	-	X
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	-	X	-	-	-	X
CM16	-	X	-	-	-	X	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	-	-	X	-	X	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	-	-	X	-	X	-	-
TOTAL	23	22	8	0	6	1	2
Compliance Percentage		73%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 37.5% - For Enrollees who were hospitalized, adequate discharge planning was performed (applies to new Enrollees). **In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 44.4% - For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees). **In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 60.0% - For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 0.0% - For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days of the Enrollee's MCO enrollment date (applies to new Enrollees).
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 48.8% - Care Manager documented a level of care for the Enrollee during the review period (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 71.4% - Care Plan was developed within 30 days of CNA completion (applies to new Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 0.0% - Care Manager sent EPSDT reminders (applies to existing Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 66.7% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to existing Enrollees). 0.0% - Appropriate outreach attempts were documented to confirm vaccination status (aged 19 and above) (applies to new Enrollees). 50.0% - Appropriate outreach attempts were documented to confirm vaccination status (aged 19 and above) (applies to existing Enrollees). 83.3% - Appropriate outreach attempts were documented to confirm dental status for new Enrollees without a confirmed dental visit (aged 1 through 20). 50.0% - Care Manager sent dental reminders to new Enrollees without a confirmed dental visit (aged 1 through 20). 20.0% - Care Manager sent dental reminders to existing Enrollees without a confirmed dental visit (aged 1 through 20).

Element	Contract Language	Reviewer Comments
		In the 2025 CM file audit the MCO scored for the DDD Population Enrollees: 80.0% - Appropriate outreach attempts were documented to confirm EPSDT status (applies to new Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 36.8% - Appropriate outreach attempts were documented to confirm EPSDT status (applies to existing Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 0.0% - Care Manager sent EPSDT reminders (aged 0 through 20 where EPSDT exam is not up to date) (applies to new and existing Enrollees). 10.0% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to existing Enrollees). 71.4% - Appropriate outreach attempts were documented to confirm vaccination status for new Enrollees (aged 19 and above). 20.9% - Appropriate outreach attempts were documented to confirm vaccination status for existing Enrollees (aged 19 and above). 27.3% - The Care Manager addressed and/or discussed dental needs with the new Enrollee (aged 21 and above). 31.5% - The Care Manager addressed and/or discussed dental needs with the existing Enrollee (aged 21 and above). 80.0% - Appropriate outreach attempts were documented to confirm dental status for new Enrollees without a confirmed dental visit (aged 1 through 20). 26.3% - Appropriate outreach attempts were documented to confirm dental status for existing Enrollees without a confirmed dental visit (aged 1 through 20). 20.0% - Care Manager sent dental reminders to new Enrollees without a confirmed dental visit (aged 1 through 20).

Element	Contract Language	Reviewer Comments
		26.3% - Care Manager sent dental reminders to existing Enrollees without a confirmed dental visit (aged 1 through 20). **In the 2025 CM file audit the MCO scored for the new DCP&P Population Enrollees:** 50.0% - Appropriate outreach attempts were documented to confirm EPSDT status (applies to new Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 0.0% - Care Manager sent EPSDT reminders (applies to new and existing Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 75.0% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to new Enrollees). 60.0% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to existing Enrollees). 0.0% - Appropriate outreach attempts were documented to confirm dental status for new Enrollees without a confirmed dental visit (aged 1 through 20). 81.8% - Appropriate outreach attempts were documented to confirm dental status for existing Enrollees without a confirmed dental visit (aged 1 through 20). 0.0% - Care Manager sent dental reminders to new Enrollees without a confirmed dental visit (aged 1 through 20). 54.5% - Care Manager sent dental reminders to existing Enrollees without a confirmed dental visit (aged 1 through 20).
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 50.0% - For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 81.2% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to new Enrollees). 45.2% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). **In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 66.7% - For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).
CM37	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	**In the 2025 CM file audit the MCO received a Not Met for the DDD Enrollee Population.** The DDD Enrollee universe file submission did not adhere to the exclusion criteria in the audit specifications resulting in a resubmission.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM16	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to new Enrollees).
2. CM6: For an IHS not completed timely or no IHS on file, ABHNJ should ensure that aggressive outreach attempts are performed and documented within 45 days of the Enrollee's MCO enrollment date (applies to new Enrollees).
3. CM7: *File Audit*: For Enrollees who are lost to contact, ABHNJ should ensure that aggressive outreach attempts are made and documented by the Care Manager (applies to existing Enrollees).
4. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees).
5. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure that appropriate outreach attempts are documented to confirm immunization status (applies to existing Enrollees).
6. CM14: For Enrollees aged 19 and above, ABHNJ should ensure that appropriate outreach attempts are documented to confirm vaccination status (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that appropriate outreach attempts are documented to confirm dental status (applies to new Enrollees).
8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that the Care Manager sends dental reminders (applies to new and existing Enrollees).
9. CM15: ABHNJ should ensure that for Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan is documented to address the Enrollee's specific care needs (applies to new Enrollees)

For the DDD Population:

1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM7: ABHNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
3. CM8: ABHNJ should ensure that the Enrollee has a Care Plan that was developed within 30 days of CNA completion (applies to new Enrollees).
4. CM8: *File Audit:* ABHNJ should ensure that the Enrollee has a Care Plan of file during the review period (applies to existing Enrollees).
5. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure that appropriate outreach attempts are documented to confirm EPSDT status when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees).

6. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure that appropriate outreach attempts are documented to confirm immunization status (applies to existing Enrollees).
8. CM14: For Enrollees aged 19 and above, ABHNJ should ensure that appropriate outreach attempts are documented to confirm vaccination status (applies to new and existing Enrollees).
9. CM14: For Enrollees aged 21 and above, ABHNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees).
10. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should document appropriate outreach attempts to confirm dental status for Enrollees (applies to new and existing).
11. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure that dental reminders are sent (applies to new and existing Enrollees).
12. CM19: ABHNJ should ensure that when appropriate for the applicable Enrollees, Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to new and existing Enrollees).
13. CM37: ABHNJ should establish a quality improvement process to ensure compliance and accuracy with audit preparation and submissions to the EQRO.

For the DCP&P Population:

1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM7 *File Audit:* ABHNJ should ensure the CNA is completed timely, within 45 days of Enrollee's MCO enrollment date (applies to new Enrollees).
3. CM8 *File Audit:* ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees).
4. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, ABHNJ should ensure that the Care Manager makes appropriate outreach attempts to confirm EPSDT status (applies to new Enrollees).
5. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, ABHNJ should ensure EPSDT reminders are sent (applies to new and existing Enrollees).
6. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure appropriate outreach attempts are made to confirm immunization status (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should document appropriate outreach attempts to confirm dental status for Enrollees (applies new to existing Enrollees).
8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure dental reminders are sent (applies to new and existing Enrollees).
9. CM19: For Enrollees demonstrating needs requiring coordination of services, ABHNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Aetna Better Health of New Jersey

Review Period July 1, 2024 – June 30, 2025

February 2026

Better healthcare, realized.

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Contract (Article 9). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 120 cases for Aetna Better Health of New Jersey (ABHNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet

eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, along with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 120 cases selected for ABHNJ, 104 Member files were reviewed and 100 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	27	27	50	104
Exclusions	2	2	0	4
Number of Files Included in Results	25	25	50	100

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's audit results for the combined MLTSS sample ranged from 85.4% to 100.0% across all three (3) subgroups for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2024 – June 30, 2025			
	Group C	Group D	Group E	Combined[3]
Assessment	100.0%	97.9%	96.8%	97.6%
Member Outreach[1]	96.0%	92.0%	--	94.0%
Face-to-Face Visits	92.6%	97.5%	94.5%	94.7%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[2]	96.7%	97.7%	96.8%	97.0%
Ongoing Care Management	84.8%	85.6%	85.6%	85.4%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[2]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 27 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 2 files excluded. All 25 files were further reviewed for compliance in 6 categories. There were 5 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested the NJ Choice Assessment (NJCA) for the Member from the Office of Community Choice Options (OCCO).*	17	25	68.0%
MCO requested the NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting an NJCA from OCCO).*	8	17	47.1%
OCCO response was received within 5 business days of the MCO request.*	17	17	100.0%
The MCO received the NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	17	0.0%
OCCO completed the NJCA which was valid during the review period.*	0	25	0.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	24	25	96.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.[1]	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	24	25	96.0%
Member was offered the participant direction option during Options Counseling.[2]	20	20	100.0%
Member chose the participant direction option.*[2]	6	20	30.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	6	6	100.0%
Member refused PCA services through an agency.*	3	14	21.4%
PCA assessment was completed with the Member during the review period.[2,3]	17	17	100.0%
PCA assessment was completed with the Member within 45 days of MLTSS enrollment.	12	17	70.6%
A cost effective analysis (CEA) was completed during the review period.	21	25	84.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	21	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	21	25	84.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%
Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	20	20	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	20	20	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	20	20	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	20	20	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	12	20	60.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	20	20	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	20	20	100.0%
Member required a Risk Management Agreement.*[1]	20	20	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	20	20	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	18	20	90.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	5	17	29.4%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	5	5	100.0%
Member experienced issues that impeded access to care.*	7	25	28.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	7	7	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	11	25	44.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	9	25	36.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	9	9	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	9	25	36.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	9	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) business days of discharge.	7	9	77.8%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	7	9	77.8%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	7	25	28.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	7	7	100.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	7	7	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	7	7	100.0%

Member had a change in placement during the review period.*	2	25	8.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	2	2	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
[2]Denominator includes all Members with PCA services (self-directed or agency) and total PCA assessments completed during the review period.
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Member receiving MLTSS services and not residing in community alternative residential setting (CARS) during the review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	20	20	100.0%
Member reported a gap in service delivery.*[1]	1	20	5.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 27 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were 2 files excluded. All 25 files were further reviewed for compliance in all 6 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	23	25	92.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%
NJCA was completed within 30 days of a referral to MLTSS.	22	23	95.7%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	23	25	92.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.	24	25	96.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	24	24	100.0%
Member had PPP services in place prior to MLTSS enrollment.*	4	25	16.0%
Member was offered the participant direction option during Options Counseling.[1]	21	21	100.0%
Member chose the participant direction option.*[1]	7	21	33.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	7	7	100.0%
Member had PCA services through an agency in place prior to MLTSS enrollment.*	9	14	64.3%
Member refused PCA services through an agency.*[1]	4	5	80.0%
PCA assessment was completed with the Member during the review period.[1,2]	8	8	100.0%
PCA assessment completed with the Member within 45 days of MLTSS enrollment.[1]	8	8	100.0%
A cost effective analysis (CEA) was completed during the review period.	23	25	92.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	23	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	23	25	92.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%

There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	25	25	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	25	25	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	25	25	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	25	25	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	21	25	84.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	23	25	92.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	24	25	96.0%
Member required a Risk Management Agreement.*[1]	24	24	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	24	24	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	20	25	80.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	7	21	33.3%

MCO completed a PCA reassessment due to changes in Member's condition.[1]	6	7	85.7%
Member experienced issues that impeded access to care.*	2	25	8.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	2	2	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	14	25	56.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	6	25	24.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	6	6	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	6	25	24.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	6	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	6	6	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	6	6	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	5	25	20.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	5	5	100.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	5	5	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	5	5	100.0%
Member had a change in placement during the review period.*	1	25	4.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	1	1	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
[2]Denominator includes all Members with PCA services (self-directed or agency) prior to MLTSS enrollment and total PCA assessments completed during the review period.
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Member reported a gap in service delivery.*[1]	1	25	4.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 50 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were no files excluded. The Member Outreach category is not assessed for Members in Group E. All 50 files were reviewed for compliance in 5 categories. There were 3 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The annual NJ Choice Assessment (NJCA) was due during the review period.*	47	50	94.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	47	47	100.0%
NJCA to reassess clinical eligibility for MLTSS was completed within 11 to 13 months from the last NJCA authorized by OCCO.	44	47	93.6%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	50	50	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.	47	47	100.0%

Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	47	47	100.0%
Member had PPP services in place prior to the review period.*[1]	19	47	40.4%
Member was offered the participant direction option during Options Counseling.[1]	28	28	100.0%
Member chose the participant direction option.*[1]	4	28	14.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	4	4	100.0%
Member had PCA services through an agency in place prior to review period.*[1]	21	24	87.5%
Member refused PCA services through an agency.*[1]	2	3	66.7%
MCO completed a PCA assessment with the Member during the review period.[1,2]	5	5	100.0%
A cost effective analysis (CEA) was completed during the review period.	40	50	80.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	40	0.0%
Member's annual cost threshold (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	47	47	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%

Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	46	47	97.9%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	46	46	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	46	46	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	46	46	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	30	46	65.2%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	39	47	83.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	49	50	98.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Care Manager completed an annual risk assessment for the Member.[1]	47	47	100.0%
Members who were identified as having a positive risk.*[1]	47	47	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.*[1]	0	0	N/A
The MCO appropriately determined the Member had no potential risks during the review period.[2]	0	0	N/A
Members who were identified as having a positive risk had a signed Risk Management Agreement with all components.[1]	47	47	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Rate is calculated by the number of "No" determinations divided by the sum of the "Yes" plus "No" determinations.

N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member required a PCA reassessment due to changes in condition.*[1,2]	32	45	71.1%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	30	32	93.8%
Member experienced issues that impeded access to care.*	17	50	34.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	16	17	94.1%

Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	26	50	52.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	32	50	64.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	31	32	96.9%
Member file indicated a disagreement with the Plan of Care.*	0	1	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	26	50	52.0%
Member refused the ten (10) business day post discharge onsite visit.*	1	26	3.8%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	1	1	100.0%
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	19	25	76.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	24	26	92.3%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	34	50	68.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	28	34	82.4%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	32	34	94.1%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	28	32	87.5%
Member had a change in placement during the review period.*	1	50	2.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to the review period and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	47	47	100.0%
Member reported a gap in service delivery.*[1]	4	47	8.5%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	4	4	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Overall, ABHNJ's audit results ranged from 87.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	21	25	84.0%
	Group D	23	25	92.0%
	Group E[4]			
	Total	44	50	88.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	47	47	100.0%
	Total	47	47	100.0%
	Group C	7	7	100.0%

#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group D	5	5	100.0%
	Group E	28	34	82.4%
	Total	40	46	87.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice Assessment.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	20	20	100.0%
	Group D	25	25	100.0%
	Group E	46	47	97.9%
	Total	91	92	98.9%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]Members who did not have a documented change in condition during the study period are excluded from this measure.
[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4]Group E Members are excluded from this measure as they are not new to MLTSS.
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.

Discussion

Limitations

None

Conclusions and Recommendations

Population-Specific conclusions, along with opportunities for improvement, are presented by category below. Recommendations are based on deficiencies identified at the group level (Groups C, D, and E).

Assessment

Across all three groups, the MCO had a combined score of 97.6% in the Assessment category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	97.9%
Group E	96.8%
Combined	97.6%

Member Outreach

Across groups, the MCO had a combined score of 94.0% in the Member Outreach category.

Group	7/1/24 to 6/30/25
Group C	96.0%
Group D	92.0%
Group E[1]	--
Combined	94.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 94.7% in the Face-to-Face Visits category.

Group	7/1/24 to 6/30/25
Group C	92.6%
Group D	97.5%
Group E	94.5%
Combined	94.7%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 97.0% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/24 to 6/30/25
Group C	96.7%
Group D	97.7%
Group E	96.8%
Combined	97.0%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 85.4% in the Ongoing Care Management category.

Group	7/1/24 to 6/30/25
Group C	84.8%
Group D	85.6%
Group E	85.6%
Combined	85.4%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

- **Group C, Group D, and Group E:** ABHNJ should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- **Group C and Group E:** For Members who are discharged to an HCBS setting, ABHNJ should ensure the onsite review occurs within ten (10) business days of discharge.

- **Group C:** For Members who are discharged to his/her own home, ABHNJ should ensure that in-home services are in place in a timely manner.

Group D:

- ABHNJ should ensure that the Member has services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard).

- For Members who require a PCA reassessment due to changes in condition, ABHNJ should ensure that a PCA reassessment is completed.

- **Group E:** For Member files that indicate a significant change in Member condition, ABHNJ should ensure that the Member's Plan of Care is amended, reviewed, and signed by the Member and/or authorized representative.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, the MCO scored above 86% in all seven (7) Performance Measures.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition.

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- **Group C:** ABHNJ should ensure that the Initial Plan of Care is completed, signed, and mailed within 45 days of MLTSS enrollment.

PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.

- **Group E:** For MLTSS Members with a change in condition, ABHNJ should ensure that the Plan of Care is amended to reflect the changes in Member condition.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2025 Annual Assessment Review of Care Management
Aetna Better Health of New Jersey

Review Period - July 1, 2024 to June 30, 2025

January 2026

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Introduction

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Background

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standards under review; interviews with key ABHNJ staff (held via Teams meeting on December 9, 2025) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on August 22, 2025, and received from the MCOs on September 12, 2025. The documentation review occurred offsite at IPRO beginning on September 15, 2025. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2024 to June 30, 2025. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore are considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2025 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. ABHNJ received an overall compliance score of 100% in 2025. In 2024, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	10	10	0	0	0	0	0
Compliance Percentage		100%					

Strengths

None

Recommendations

None

Findings for Improvement

None

Appendix C – FC/WCHP 2025 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment

Fidelis Care

Review Period: January 1, 2024 to December 31, 2024

September 2025

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

MCO Care Management Chart Audit

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a

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

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant Enrollees from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 390 cases for Fidelis Care.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees (including a 30% oversample required for substitutions or exclusions) was selected for the General, DDD, and DCP&P Populations. If the MCO's sample did not meet the sample size of 130 for each individual population, the entire population was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible new and existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL).	Capitation Codes 17399, 37399, 57599, 59199, 87399, and 99499.	Capitation Codes 49499 or 81299 ***OR*** PSC 600 and County Code less than 22. ***AND*** (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499).
	IPRO will pull a random sample from the universes provided as follows: 1) 65 Enrollees new to the MCO and Care Management anytime from 1/1/2024 through 11/16/2024 ***AND*** 2) 65 existing Enrollees new to Care Management from 3/1/2024	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DDD Enrollees in Care Management ***AND*** 2) ALL existing eligible DDD Enrollees in Care Management.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DCP&P Enrollees in Care Management ***AND*** 2) ALL existing eligible DCP&P Enrollees in Care Management.

	through 11/16/2024 from the universes provided.* *Random sample size modified by IPRO.	IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.* *Random sample size modified by IPRO.	IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.* *Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2024	>= 6 months as of 12/31/2024	>= 6 months and < 18 years as of 12/31/2024
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024
• Existing Enrollees	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024
Current Enrollment	Enrolled as of 12/31/2024 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2024 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.

Introductory E-Mail

For this year's chart audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year's audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's secure S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted file reviews over a five-week period. Inter-rater reliability was maintained through the use of a standardized Audit Tool, along with ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite chart audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care's 2025 CM Audit results for the review period 1/01/2024 to 12/31/2024 ranged from 50.0% to 100.0% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=20)
Identification[1]	72.4%		
Outreach[2,3]	50.0%	100.0%	50.0%
Preventive Services[3]	100.0%	92.2%	100.0%
Continuity of Care[3]	98.0%	96.7%	97.8%
Coordination of Services[3]	99.4%	95.1%	93.5%

[1]The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of new and existing population specific rates.

General Population Findings

A combined total of 113 files were reviewed for the new and existing General Population. There were 13 files excluded from the analysis as they did not meet the Care Management enrollment criteria for the review period. The remaining 100 files were assessed for compliance across the following five categories.

Identification

The Identification category applies to GP Enrollees (22) new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024. The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.

Table 3: Identification – General Population - Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2024 to 12/31/2024).*	11	22	50.0%
IHS was completed for the Enrollee within 45 days of MCO enrollment date.*	8	11	72.7%

Identification	General Population		
	Numerator	Denominator	Rate
For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date.	6	14	42.9%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	15	15	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (22) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (78) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	22	22	100.0%	78	78	100.0%
MCO completed the CNA timely (within 30 days from IHS score of 5 or greater, or from date of identification of CM needs).*	12	22	54.5%	74	78	94.9%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs.[1]	3	10	30.0%	4	4	100.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 10 files with untimely CNAs for new GP Enrollees and 4 files with untimely CNAs for existing GP Enrollees.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (22) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (78) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 5: Preventive Services – General Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	15	15	100.0%	18	18	100.0%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	0	N/A
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	0	N/A

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	11	14	78.6%	14	16	87.5%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	3	100.0%	2	2	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	6	6	100.0%	36	36	100.0%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	0	0	N/A	0	0	N/A
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	7	7	100.0%	60	60	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	7	15	46.7%	10	18	55.6%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	8	8	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	8	8	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (22) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (78) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	22	22	100.0%	78	78	100.0%
CNA was completed timely (within 30 days of identification of CM needs).	12	22	54.5%	74	78	94.9%
CNA contained all elements of the State approved CNA tool.	22	22	100.0%	78	78	100.0%
Care Manager documented a level of care for the Enrollee during the review period.	22	22	100.0%	78	78	100.0%
The Enrollee had a Care Plan on file during the review period.	22	22	100.0%	78	78	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	22	22	100.0%	77	78	98.7%
Care Plan was completed for the Enrollee that included all required components.	22	22	100.0%	78	78	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	22	22	100.0%	78	78	100.0%

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	6	6	100.0%	8	8	100.0%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	10	10	100.0%	10	10	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	10	10	100.0%	10	10	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (22) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (78) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	18	18	100.0%	33	33	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	12	12	100.0%	44	45	97.8%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	9	9	100.0%	24	24	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	4	4	100.0%	18	18	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

A combined total of 100 files were reviewed for the new and existing DDD Population. No files were excluded from the analysis. A total of 100 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	26	50	52.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	25	26	96.2%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	25	25	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 1 file with an untimely CNA and 24 files without a CNA.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	16	20	80.0%	5	7	71.4%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	4	4	100.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	4	4	100.0%	2	2	100.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	3	11	27.3%	1	2	50.0%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	8	8	100.0%	0	1	0.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	7	33	21.2%	11	29	37.9%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	25	26	96.2%	14	18	77.8%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	28	30	93.3%	40	43	93.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	10	20	50.0%	3	7	42.9%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	10	10	100.0%	3	4	75.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	10	10	100.0%	3	4	75.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	26	50	52.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	25	26	96.2%			
CNA contained all elements of the State approved CNA tool.	26	26	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	26	26	100.0%	47	50	94.0%
The Enrollee had a Care Plan on file during the review period.	50	50	100.0%	45	50	90.0%
Care Plan was developed within 30 days of CNA completion.[1]	26	26	100.0%			
Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	45	45	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	44	50	88.0%	45	45	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	2	2	100.0%	1	1	100.0%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	3	3	100.0%	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	3	3	100.0%	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 11: Coordination of Services – DDD Population - New and Existing Enrollees in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	48	50	96.0%	46	50	92.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	23	23	100.0%	25	26	96.2%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	8	8	100.0%	0	0	N/A
For Enrollees who were hospitalized, adequate discharge planning was performed.	4	4	100.0%	1	2	50.0%
For Enrollees hospitalized with a mental/behavioral health diagnosis, the Care Manager made aggressive outreach attempts to determine follow-up status with a mental/behavioral health provider.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

A combined total of 130 files were reviewed for the new and existing DCP&P Population. There were 110 files excluded from the analysis due to adoption, adoption subsidy, interstate services, and reunification with parent. The remaining 20 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DCP&P Enrollees (3) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population - Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	2	3	66.7%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	1	2	50.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	1	2	50.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 1 file with an untimely CNA and 1 file without a CNA.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (3) and existing DCP&P Enrollees (17) in Care Management during the 2024 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	1	3	33.3%	15	17	88.2%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	2	2	100.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	0	3	0.0%	6	17	35.3%
Appropriate outreach attempts were documented to confirm	3	3	100.0%	11	11	100.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
immunization status (aged 0 through 18).						
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	1	3	33.3%	14	17	82.4%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	2	2	100.0%	3	3	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	2	2	100.0%	3	3	100.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations.

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (3) and existing DCP&P Enrollees (17) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	2	3	66.7%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	1	2	50.0%			
CNA contained all elements of the State approved CNA tool.	2	2	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	2	2	100.0%	17	17	100.0%
The Enrollee had a Care Plan on file during the review period.	2	3	66.7%	17	17	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	2	2	100.0%			
Care Plan was completed for the Enrollee that included all required components.	2	2	100.0%	17	17	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	2	2	100.0%	17	17	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	0	0	N/A	5	5	100.0%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	0	0	N/A	1	1	100.0%

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	1	1	100.0%

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (3) and existing DCP&P Enrollees (17) in Care Management during the 2024 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	3	3	100.0%	15	17	88.2%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	1	1	100.0%	3	3	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	1	1	100.0%	5	5	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	0	0	N/A	1	1	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

Limitations

Fidelis Care had a combined total of 110 file exclusions for the DCP&P Population new and existing Enrollees. As a result, the total files assessed for compliance were 3 (new Enrollees) and 17 (existing Enrollees). Rates with a denominator of less than 30 are not statistically significant and should be considered cautiously.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (DDD Population) (100.0%)

- Preventive Services (General Population) (100.0%)
- Preventive Services (DDD Population) (92.2%)
- Preventive Services (DCP&P Population) (100.0%)

- Continuity of Care (General Population) (98.0%)
- Continuity of Care (DDD Population) (96.7%)
- Continuity of Care (DCP&P Population) (97.8%)

- Coordination of Services (General Population) (99.4%)
- Coordination of Services (DDD Population) (95.1%)
- Coordination of Services (DCP&P Population) (93.5%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (72.4%)

- Outreach (General Population) (50.0%)
- Outreach (DCP&P Population) (50.0%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Fidelis Care, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key Fidelis Care staff via TEAMS held on June 30, 2025, and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 7, 2025, and submissions were received from the MCOs on April 4, 2025. The documentation review occurred offsite at IPRO beginning on April 7, 2025. The audit review team was made up of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2024 to December 31, 2024.

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

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A – Not Applicable	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. Fidelis Care received an overall compliance score of 87% in 2025. In 2024, the MCO received a score of 87%. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Where appropriate, assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2024 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of Fidelis Care's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s).

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	X	X	-	-	-	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	X	X	-	-	-	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	X	X	-	-	-	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**26**	**26**	**4**	**0**	**4**	**0**	**0**
Compliance Percentage		**87%**					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 50.0% - For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 42.9% - For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 30% - For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs (applies to new Enrollees). **In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50% - For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment (applies to new Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the existing DDD Population Enrollees:** 0.0% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18). 77.8% - Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above). 75.0% - Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20). 75.0% - Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: For an IHS not completed timely or no IHS on file, Fidelis Care should ensure that aggressive outreach attempts are performed and documented within 45 days from the Enrollee's MCO enrollment date (applies to new Enrollees).
2. CM7: For CNAs not completed timely or no CNA on file, Fidelis Care should ensure that aggressive efforts are made to complete the CNA within 30 days of identification of CM needs (applies to new Enrollees).
3. CM7 *File Audit:* Fidelis Care should ensure that a CNA is completed timely, within 30 days of identification of CM needs (applies to new Enrollees).

For the DDD Population:

1. CM2: Fidelis Care should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM14: For Enrollees aged 0 through 18, Fidelis Care should ensure that appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees).
3. CM14: For Enrollees aged 19 and above, Fidelis Care should ensure that appropriate outreach attempts to confirm vaccination status are documented (applies to existing Enrollees).
4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees).
5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure dental reminders are sent (applies to existing Enrollees).

For the DCP&P Population:

1. CM7: For CNAs not completed timely or no CNA on file, Fidelis Care should ensure that aggressive efforts are made to complete the CNA within 45 days of MCO enrollment (applies to new Enrollees).
2. CM7 *File Audit:* Fidelis Care should ensure the CNA is completed timely, within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees).
3. CM8 *File Audit:* Fidelis Care should ensure that the Enrollee has a Care Plan on file during the review period (applies to new Enrollees).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Fidelis Care

Review Period July 1, 2024 – June 30, 2025

February 2026

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ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Managed Care Contract (Article 9). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 120 cases for Fidelis Care, including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet

eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, along with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 120 cases selected for FC, 111 Member files were reviewed and 100 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	27	25	59	111
Exclusions	2	0	9	11
Number of Files Included in Results	25	25	50	100

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care's audit results for the combined MLTSS sample ranged from 68.0% to 100.0% across all three (3) subgroups for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2024 – June 30, 2025			
	Group C	Group D	Group E	Combined[3]
Assessment	100.0%	100.0%	100.0%	100.0%
Member Outreach[1]	76.0%	60.0%	--	68.0%
Face-to-Face Visits	97.9%	77.7%	90.3%	90.0%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[2]	95.0%	95.4%	95.1%	95.1%
Ongoing Care Management	91.8%	89.9%	83.5%	86.2%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[2]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 27 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 2 files excluded. All 25 files were further reviewed for compliance in 6 categories. There were 4 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested the NJ Choice Assessment (NJCA) for the Member from the Office of Community Choice Options (OCCO).*	1	25	4.0%
MCO requested the NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting an NJCA from OCCO).*	1	1	100.0%
OCCO response was received within 5 business days of the MCO request.*	0	1	0.0%
The MCO received the NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	1	0.0%
OCCO completed the NJCA which was valid during the review period.*	0	25	0.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	19	25	76.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	24	25	96.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	1	1	100.0%
MCO completed Options Counseling with the Member or authorized representative.[1]	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	24	25	96.0%
Member was offered the participant direction option during Options Counseling.[2]	21	21	100.0%
Member chose the participant direction option.*[2]	10	21	47.6%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	10	10	100.0%
Member refused PCA services through an agency.*[2]	4	11	36.4%
PCA assessment was completed with the Member during the review period.[2,3]	17	17	100.0%
PCA assessment was completed with the Member within 45 days of MLTSS enrollment.[2]	17	17	100.0%
A cost effective analysis (CEA) was completed during the review period.	23	25	92.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	23	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	22	25	88.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%
Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of	25	25	100.0%

action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).			
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	21	21	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	21	21	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	21	21	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	21	21	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	21	21	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	21	21	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	21	21	100.0%
Member required a Risk Management Agreement.*[1]	16	21	76.2%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	16	6.3%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	21	21	100.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	0	17	0.0%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	0	0	N/A

Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	19	25	76.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	0	25	0.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	0	0	N/A
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	1	25	4.0%
Member refused the ten (10) business day post discharge onsite visit.*	1	1	100.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) business days of discharge.	0	0	N/A
Member was discharged to his/her own home and in-home services were in place in a timely manner.	1	1	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	0	25	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	0	0	N/A
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	0	0	N/A
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	0	0	N/A
Member had a change in placement during the review period.*	0	25	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Member receiving MLTSS services and not residing in community alternative residential setting (CARS) during the review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	21	21	100.0%
Member reported a gap in service delivery.*[1]	0	21	0.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were no files excluded. All 25 files were further reviewed for compliance in all 6 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	Rate
Member had a Screen for Community Services (SCS) tool completed.*	21	25	84.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%
NJCA was completed within 30 days of a referral to MLTSS.	21	21	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	15	25	60.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A

MCO completed Options Counseling with the Member or authorized representative.	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	5	25	20.0%
Member had PPP services in place prior to MLTSS enrollment.*	8	25	32.0%
Member was offered the participant direction option during Options Counseling.[1]	17	17	100.0%
Member chose the participant direction option.*[1]	0	17	0.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	0	0	N/A
Member had PCA services through an agency in place prior to MLTSS enrollment.*	13	17	76.5%
Member refused PCA services through an agency.*[1]	3	4	75.0%
PCA assessment was completed with the Member during the review period.[1,2]	1	1	100.0%
PCA assessment completed with the Member within 45 days of MLTSS enrollment.[1]	1	1	100.0%
A cost effective analysis (CEA) was completed during the review period.	24	25	96.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	24	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	24	25	96.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential	25	25	100.0%

barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).			
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	25	25	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	25	25	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	25	25	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	25	25	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	25	25	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	25	25	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	25	25	100.0%
Member required a Risk Management Agreement.*[1]	17	25	68.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	0	17	0.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	25	25	100.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	1	22	4.5%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	1	1	100.0%
Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%

Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	17	25	68.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	1	25	4.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	1	1	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	1	25	4.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	1	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	1	1	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	1	1	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	0	25	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	0	0	N/A
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	0	0	N/A
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	0	0	N/A
Member had a change in placement during the review period.*	0	25	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to MLTSS enrollment and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Member reported a gap in service delivery.*[1]	0	25	0.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
N/A: Not Applicable

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 59 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 9 files excluded. The Member Outreach category is not assessed for Members in Group E. All 50 files were reviewed for compliance in 5 categories. There were 5 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The annual NJ Choice Assessment (NJCA) was due during the review period.*	50	50	100.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	50	50	100.0%
NJCA to reassess clinical eligibility for MLTSS was completed within 11 to 13 months from the last NJCA authorized by OCCO.	50	50	100.0%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	50	50	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.	50	50	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	37	50	74.0%
Member had PPP services in place prior to the review period. *[1]	22	45	48.9%
Member was offered the participant direction option during Options Counseling.[1]	23	23	100.0%

Member chose the participant direction option.*[1]	1	23	4.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had PCA services through an agency in place prior to review period.*[1]	16	22	72.7%
Member refused PCA services through an agency.*[1]	5	6	83.3%
MCO completed a PCA assessment with the Member during the review period.[1,2]	2	2	100.0%
A cost effective analysis (CEA) was completed during the review period.	46	50	92.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	46	0.0%
Member's annual cost threshold (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	48	50	96.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	45	45	100.0%

Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	45	45	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	45	45	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	45	45	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	43	45	95.6%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	45	45	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	49	50	98.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Care Manager completed an annual risk assessment for the Member.[1]	45	45	100.0%
Members who were identified as having a positive risk.*[1]	1	45	2.2%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.*[1]	35	44	79.5%
The MCO appropriately determined the Member had no potential risks during the review period.[2]	9	44	20.5%
Members who were identified as having a positive risk had a signed Risk Management Agreement with all components.[1]	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Rate is calculated by the number of "No" determinations divided by the sum of the "Yes" plus "No" determinations.

Ongoing Care Management	N	D	Rate
Member required a PCA reassessment due to changes in condition.*[1,2]	17	40	42.5%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	17	17	100.0%
Member experienced issues that impeded access to care.*	1	50	2.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	1	0.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	23	50	46.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	18	50	36.0%

Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	15	18	83.3%
Member file indicated a disagreement with the Plan of Care.*	0	3	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	19	50	38.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	19	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	14	19	73.7%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	19	19	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	27	50	54.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	24	27	88.9%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	27	27	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	25	27	92.6%
Member had a change in placement during the review period.*	5	50	10.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	3	5	60.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to the review period and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	45	45	100.0%
Member reported a gap in service delivery.*[1]	0	45	0.0%

Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Overall, Fidelis Care's audit results ranged from 88.9% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	22	25	88.0%
	Group D	24	25	96.0%
	Group E[4]			
	Total	46	50	92.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	48	50	96.0%
	Total	48	50	96.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	0	0	N/A
	Group D	0	0	N/A
	Group E	24	27	88.9%
	Total	24	27	88.9%

#10. Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice Assessment.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	21	21	100.0%
	Group D	25	25	100.0%
	Group E	45	45	100.0%
	Total	91	91	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]Members who did not have a documented change in condition during the study period are excluded from this measure.
[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4]Group E Members are excluded from this measure as they are not new to MLTSS.
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.
N/A: Not Applicable. No Members in Group C or Group D met criteria for this measure.

Discussion

Limitations

None.

Conclusions and Recommendations

Population-Specific conclusions, along with opportunities for improvement, are presented by category below. Recommendations are based on deficiencies identified at the group level (Groups C, D, and E).

Assessment

Across all three groups, the MCO had a combined score of 100.0% in the Assessment category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Member Outreach

Across groups, the MCO had a combined score of 68.0% in the Member Outreach category.

Group	7/1/24 to 6/30/25
Group C	76.0%
Group D	60.0%
Group E[1]	--
Combined	68.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group C and Group D**: Fidelis Care should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 90.0% in the Face-to-Face Visits category.

Group	7/1/24 to 6/30/25
Group C	97.9%
Group D	77.7%
Group E	90.3%
Combined	90.0%

Opportunities for Improvement for elements at the group level in the *Face-to-Face Visits* category include the following:

- **Group D**: Fidelis Care should ensure that the Options Counseling Summary form is mailed to the Member within 5 days of OCCO determination.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 95.1% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/24 to 6/30/25
Group C	95.0%
Group D	95.4%
Group E	95.1%
Combined	95.1%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 86.2% in the Ongoing Care Management category.

Group	7/1/24 to 6/30/25
Group C	91.8%
Group D	89.9%
Group E	83.5%
Combined	86.2%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

Group E:

- Fidelis Care should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- For Member files that indicated a change from the initial Plan of Care, Fidelis Care should ensure there is documentation that the Member's Plan of Care is updated and/or reviewed, Member agreed with the Plan of Care, and the Member signed and was provided with a copy of the Plan of Care.

- For Members who were discharged to a HCBS setting, Fidelis Care should ensure that the onsite review occurs within ten (10) business days of discharge.

- For Members with a change in placement indicated, Fidelis Care should ensure there is documentation of a discussion with the Member before the change is made.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, Fidelis Care scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2025 Annual Assessment Review of Care Management
Fidelis Care

Review Period - July 1, 2024 to June 30, 2025

January 2026

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Introduction

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Background

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Fidelis Care (FC) as evidence of compliance of the standards under review; interviews with key FC staff (held via Teams meeting on December 11, 2025) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on August 22, 2025, and received from the MCOs on September 12, 2025. The documentation review occurred offsite at IPRO beginning on September 15, 2025. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2024 to June 30, 2025. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore are considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2025 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. FC received an overall compliance score of 100% in 2025. In 2024, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

Appendix D – HNJH 2025 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Horizon New Jersey Health

Review Period: January 1, 2024 to December 31, 2024

September 2025

Corporate Headquarters
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ISO 9001:2015 CERTIFIED

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

MCO Care Management Chart Audit

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a

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

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant Enrollees from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 390 cases for Horizon New Jersey Health (HNJH).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees (including a 30% oversample required for substitutions or exclusions) was selected for the General, DDD, and DCP&P Populations. If the MCO's sample did not meet the sample size of 130 for each individual population, the entire population was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible new and existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL).	Capitation Codes 17399, 37399, 57599, 59199, 87399, and 99499.	Capitation Codes 49499 or 81299 ***OR*** PSC 600 and County Code less than 22. ***AND*** (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499).
	IPRO will pull a random sample from the universes provided as follows: 1) 65 Enrollees new to the MCO and Care Management anytime from 1/1/2024 through 11/16/2024 ***AND*** 2) 65 existing Enrollees new to Care Management from 3/1/2024	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DDD Enrollees in Care Management ***AND*** 2) ALL existing eligible DDD Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DDD Enrollees	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DCP&P Enrollees in Care Management ***AND*** 2) ALL existing eligible DCP&P Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DCP&P

	through 11/16/2024 from the universes provided.* *Random sample size modified by IPRO.	in Care Management per MCO from the universes provided.* *Random sample size modified by IPRO.	Enrollees in Care Management per MCO from the universes provided.* *Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2024	>= 6 months as of 12/31/2024	>= 6 months and < 18 years as of 12/31/2024
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024
• Existing Enrollees	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024
Current Enrollment	Enrolled as of 12/31/2024 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2024 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.

Introductory E-Mail

For this year's chart audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year's audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's secure S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted file reviews over a five-week period. Inter-rater reliability was maintained through the use of a standardized Audit Tool, along with ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite chart audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's 2025 CM Audit results for the review period 1/01/2024 to 12/31/2024 ranged from 50.0% to 100.0% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=84)
Identification[1]	77.5%		
Outreach[2,3]	94.4%	100.0%	100.0%
Preventive Services[3]	100.0%	66.2%	50.0%
Continuity of Care[3]	98.6%	87.9%	95.1%
Coordination of Services[3]	99.5%	73.0%	87.7%

[1]The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of new and existing population specific rates.

General Population Findings

A combined total of 114 files were reviewed for the new and existing General Population. There were 14 files excluded from the analysis for TPL or they did not meet the date criteria for enrollment in Care Management during the review period. The remaining 100 files were assessed for compliance across the following five categories.

Identification

The Identification category applies to GP Enrollees (40) new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024. The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.

Table 3: Identification – General Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2024 to 12/31/2024).*	27	40	67.5%
IHS was completed for the Enrollee within 45 days of MCO enrollment date.*	20	27	74.1%

Identification	General Population		
	Numerator	Denominator	Rate
For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date.	11	20	55.0%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	20	20	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (40) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (60) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	40	40	100.0%	60	60	100.0%
MCO completed the CNA timely (within 30 days from IHS score of 5 or greater, or from date of identification of CM needs).*	36	40	90.0%	54	60	90.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs.[1]	3	4	75.0%	6	6	100.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	5	5	100.0%	3	3	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 4 files with untimely CNAs for new GP Enrollees and 6 files with untimely CNAs for existing GP Enrollees.

Preventive Services

The Preventive Services category applies to new GP Enrollees (40) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (60) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	25	26	96.2%	18	25	72.0%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	7	7	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	7	7	100.0%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	23	26	88.5%	19	22	86.4%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	3	100.0%	3	3	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	5	8	62.5%	19	28	67.9%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	3	3	100.0%	9	9	100.0%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	14	14	100.0%	35	35	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	9	21	42.9%	15	25	60.0%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	12	12	100.0%	10	10	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	12	12	100.0%	10	10	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (40) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (60) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	40	40	100.0%	60	60	100.0%
CNA was completed timely (within 30 days of identification of CM needs).	36	40	90.0%	54	60	90.0%
CNA contained all elements of the State approved CNA tool.	40	40	100.0%	60	60	100.0%
Care Manager documented a level of care for the Enrollee during the review period.	40	40	100.0%	60	60	100.0%
The Enrollee had a Care Plan on file during the review period.	40	40	100.0%	60	60	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	40	40	100.0%	60	60	100.0%
Care Plan was completed for the Enrollee that included all required components.	40	40	100.0%	60	60	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	40	40	100.0%	60	60	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	7	7	100.0%	7	7	100.0%

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	5	5	100.0%	2	2	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	5	5	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (40) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (60) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	15	15	100.0%	8	8	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	33	33	100.0%	52	52	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	21	21	100.0%	43	43	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	6	7	85.7%	12	12	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

A combined total of 103 files were reviewed between the new and existing DDD population. There were 3 files excluded from the analysis due to TPL. The remaining 100 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population – Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	48	50	96.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	33	48	68.8%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	17	17	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 15 files with untimely CNAs and 2 files without a CNA.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	28	33	84.8%	11	17	64.7%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	5	5	100.0%	2	6	33.3%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	5	5	100.0%	0	6	0.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	14	24	58.3%	5	14	35.7%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	10	10	100.0%	1	9	11.1%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	9	16	56.3%	20	34	58.8%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	7	7	100.0%	4	14	28.6%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	17	17	100.0%	23	33	69.7%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	23	33	69.7%	12	17	70.6%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	9	10	90.0%	1	5	20.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	9	10	90.0%	1	5	20.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	48	50	96.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	33	48	68.8%			
CNA contained all elements of the State approved CNA tool.	48	48	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	48	48	100.0%	50	50	100.0%
The Enrollee had a Care Plan on file during the review period.	50	50	100.0%	14	50	28.0%
Care Plan was developed within 30 days of CNA completion.[1]	48	48	100.0%			
Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	11	14	78.6%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	50	50	100.0%	10	14	71.4%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	7	8	87.5%	7	7	100.0%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	1	1	100.0%	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	41	50	82.0%	6	50	12.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	38	38	100.0%	10	10	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	32	32	100.0%	7	7	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	5	5	100.0%	4	4	100.0%
For Enrollees hospitalized with a mental/behavioral health diagnosis, the Care Manager made aggressive outreach attempts to determine follow-up status with a mental/behavioral health provider.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

A combined total of 130 files were reviewed between the new and existing DCP&P Population. There were 46 files excluded from the analysis due to adoption, adoption subsidy, interstate services, and reunification with a parent. The remaining 84 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DCP&P Enrollees (54) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population- Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	53	54	98.1%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	46	53	86.8%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	8	8	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 7 files with untimely CNAs and 1 file without a CNA.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (54) and existing DCP&P Enrollees (30) in Care Management during the 2024 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	53	54	98.1%	25	30	83.3%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	1	5	20.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	1	5	20.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	50	53	94.3%	21	30	70.0%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	3	100.0%	1	9	11.1%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	33	36	91.7%	24	29	82.8%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	3	5	60.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	3	5	60.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations.

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (54) and existing DCP&P Enrollees (30) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	53	54	98.1%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	46	53	86.8%			
CNA contained all elements of the State approved CNA tool.	53	53	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	53	53	100.0%	30	30	100.0%
The Enrollee had a Care Plan on file during the review period.	54	54	100.0%	14	30	46.7%
Care Plan was developed within 30 days of CNA completion.[1]	53	53	100.0%			
Care Plan was completed for the Enrollee that included all required components.	54	54	100.0%	14	14	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	54	54	100.0%	14	14	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	9	9	100.0%	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (54) and existing DCP&P Enrollees (30) in Care Management during the 2024 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	54	54	100.0%	16	30	53.3%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	18	18	100.0%	2	2	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	8	8	100.0%	1	1	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

Limitations

Rates with a denominator of less than 30 are not statistically significant and should be considered cautiously.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (94.4%)
- Outreach (DDD Population) (100.0%)
- Outreach (DCP&P Population) (100.0%)

- Preventive Services (General Population) (100.0%)

- Continuity of Care (General Population) (98.6%)
- Continuity of Care (DDD Population) (87.9%)
- Continuity of Care (DCP&P Population) (95.1%)

- Coordination of Services (General Population) (99.5%)
- Coordination of Services (DCP&P Population) (87.7%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (77.5%)

- Preventive Services (DDD Population) (66.2%)
- Preventive Services (DCP&P Population) (50.0%)

- Coordination of Services (DDD Population) (73.0%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Horizon New Jersey Health (HNJH), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key HNJH staff via TEAMS held on July 17, 2025, and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 7, 2025, and submissions were received from the MCOs on April 4, 2025. The documentation review occurred offsite at IPRO beginning on April 7, 2025. The audit review team was made up of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2024 to December 31, 2024.

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

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A – Not Applicable	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. HNJH received an overall compliance score of 80% in 2025. In 2024, the MCO received a score of 57%. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Where appropriate, assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2024 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of HNJH's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	X	-	-	-	X	-
CM3	X	X	-	-	-	-	-
CM4	-	X	-	-	-	X	-
CM5	-	X	-	-	-	X	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	-	X	-	X	-	-
CM9	-	X	-	-	-	X	-
CM10	-	X	-	-	-	X	-
CM11	-	-	X	-	X	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-
CM18c	-	X	-	-	-	X	-
CM18d	X	X	-	-	-	-	-
CM19	-	-	X	-	X	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	-	X	-	-	-	X	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**17**	**24**	**6**	**0**	**6**	**7**	**0**
Compliance Percentage		**80%**					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 55.0% - For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days of the Enrollee's MCO enrollment date (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 75.0% - For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs (applies to new Enrollees).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 78.6% - Care Plan was completed for the Enrollee that included all required components (applies to existing Enrollees).
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 71.4% - Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the existing DDD Population Enrollees:** 33.3% - Appropriate outreach attempts were documented to confirm EPSDT status where EPSDT status is not up to date (aged 0 through 20). 0.0% - EPSDT reminders were sent to Enrollees where EPSDT exam is not up to date (aged 0 through 20). 11.1% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18). 28.6% - Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above). 69.7% - Care Manager addressed and/or discussed dental needs with the Enrollee (aged 21 and above). 20.0% - Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20). 20.0% - Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20). **In the 2025 CM file audit the MCO scored for the existing DCP&P Population Enrollees:** 20.0% - Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date (aged 0 through 20). 20.0% - EPSDT reminders were sent (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 11.1% - Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).

Element	Contract Language	Reviewer Comments
		60.0% - Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20). 60.0% - Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2025 CM file audit the MCO scored for the DDD and DCP&P Enrollee Populations in the following element:** When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD). 82.0% - New DDD Enrollees 12.0% - Existing DDD Enrollees 53.3% - Existing DCP&P Enrollees

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.
CM4	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.
CM5	**4.6.5.A** **Use a multi-disciplinary team to manage the care of Enrollees needing Care Management**. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital.

Element	Contract Language
CM9	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs and level of care. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.
CM10	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.
CM18c	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.
CM23	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: For an IHS not completed timely or no IHS on file, HNJH should ensure that aggressive outreach attempts are performed and documented within 45 days from the Enrollee's MCO enrollment date (applies to new Enrollees).
2. CM7: HNJH should ensure aggressive efforts are made to complete CNAs within 30 days of identification of CM needs (applies to new Enrollees).

For the DDD Population:

1. CM7: *File Audit*: HNJH should ensure that the CNA is completed timely, within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees).
2. CM8: *File Audit*: HNJH should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).

3. CM8: HNJH should ensure that the Enrollee's Care Plan includes all required components (applies to existing Enrollees).
4. CM11: HNJH should ensure that the Enrollees Care Plan is reviewed/monitored during the review period. At a minimum annually (applies to existing Enrollees).
5. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, HNJH should ensure that appropriate outreach attempts to confirm EPSDT status are documented (applies to existing Enrollees).
6. CM14: For Enrollees aged 0 through 20, HNJH should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees).
7. CM14: For Enrollees aged 0 through 18, HNJH should ensure that appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees).
8. CM14: For Enrollees aged 19 and above, HNJH should ensure that appropriate outreach attempts to confirm vaccination status are documented (applies to existing Enrollees).
9. CM14: For Enrollees aged 21 and above, HNJH should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees).
10. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees).
11. For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees).
12. CM19: HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to new and existing Enrollees).

For the DCP&P Population:

1. CM8 *File Audit*: HNJH should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).
2. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, HNJH should ensure that the Care Manager makes appropriate outreach attempts to confirm EPSDT status (applies to existing Enrollees).
3. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, HNJH should ensure EPSDT reminders are sent (applies to existing Enrollees).
4. CM14: For Enrollees aged 0 through 18, HNJH should ensure appropriate outreach attempts to confirm immunization status are documented (applies to existing Enrollees).
5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure appropriate outreach attempts to confirm dental status are documented (applies to existing Enrollees).
6. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees).
7. CM19: HNJH should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Horizon New Jersey Health

Review Period July 1, 2024 – June 30, 2025

February 2026

Better healthcare, realized.

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Managed Care Contract (Article 9). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 120 cases for Horizon New Jersey Health (HNJH) including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, along with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 120 cases selected for HNJH, 101 Member files were reviewed and 100 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	25	25	51	101
Exclusions	0	0	1	1
Number of Files Included in Results	25	25	50	100

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's audit results for the combined MLTSS sample ranged from 75.6% to 99.4% across all three (3) subgroups for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2024 – June 30, 2025			
	Group C	Group D	Group E	Combined[3]
Assessment	100.0%	95.8%	100.0%	98.8%
Member Outreach[1]	100.0%	76.0%	--	88.0%
Face-to-Face Visits	77.8%	80.9%	70.5%	75.6%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[2]	99.7%	97.2%	97.1%	97.7%
Ongoing Care Management	98.9%	92.8%	97.6%	96.6%
Gaps in Care/Critical Incidents	100.0%	97.6%	100.0%	99.4%

[1]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[2]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 25 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were no files excluded. All 25 files were further reviewed for compliance in 6 categories. There were 10 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested the NJ Choice Assessment (NJCA) for the Member from the Office of Community Choice Options (OCCO).*	0	25	0.0%
MCO requested the NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting an NJCA from OCCO).*	0	0	N/A
OCCO response was received within 5 business days of the MCO request.*	0	0	N/A
The MCO received the NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	0	N/A
OCCO completed the NJCA which was valid during the review period.*	0	25	0.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%

*Not included in aggregate score calculation.
N/A: Not Applicable

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	25	25	100.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.[1]	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	0	25	0.0%
Member was offered the participant direction option during Options Counseling.[2]	15	15	100.0%
Member chose the participant direction option.*[2]	8	15	53.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	7	8	87.5%
Member refused PCA services through an agency.*	1	7	14.3%
PCA assessment was completed with the Member during the review period.[2,3]	14	14	100.0%
PCA assessment was completed with the Member within 45 days of MLTSS enrollment.	13	14	92.9%
A cost effective analysis (CEA) was completed during the review period.	24	25	96.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	24	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	25	25	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%
Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	15	15	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	15	15	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	15	15	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	15	15	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	15	15	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	15	15	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	15	15	100.0%
Member required a Risk Management Agreement.[1]*	2	15	13.3%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	2	50.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	15	15	100.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	4	14	28.6%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	4	4	100.0%
Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	24	25	96.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	0	25	0.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	0	0	N/A
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	1	25	4.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	1	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) business days of discharge.	1	1	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	1	1	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	4	25	16.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	4	4	100.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	4	4	100.0%

Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	4	4	100.0%
Member had a change in placement during the review period.*	10	25	40.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	10	10	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
[2]Denominator includes all Members with PCA services (self-directed or agency) and total PCA assessments completed during the review period.
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Member receiving MLTSS services and not residing in community alternative residential setting (CARS) during the review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	15	15	100.0%
Member reported a gap in service delivery.*[1]	0	15	0.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 25 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were no files excluded. All 25 files were further reviewed for compliance in all 6 categories. There were 9 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	23	25	92.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%
NJCA was completed within 30 days of a referral to MLTSS.	21	23	91.3%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	19	25	76.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A
MCO completed Options Counseling with the Member or authorized representative.	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.[1]	0	16	0.0%
Member had PPP services in place prior to MLTSS enrollment.*	4	25	16.0%
Member was offered the participant direction option during Options Counseling.[2]	20	21	95.2%
Member chose the participant direction option.*[2]	5	20	25.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	5	5	100.0%
Member had PCA services through an agency in place prior to MLTSS enrollment.*	1	15	6.7%
Member refused PCA services through an agency.*[2]	10	14	71.4%
PCA assessment was completed with the Member during the review period.[2,3]	9	9	100.0%
PCA assessment completed with the Member within 45 days of MLTSS enrollment.[2]	8	9	88.9%
A cost effective analysis (CEA) was completed during the review period.	22	25	88.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT). *	0	22	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes 9 Members where OCCO completed a NJCA secondary review.
[2] Denominator excludes Members residing in CARS.
[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	23	25	92.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%

Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	25	25	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	16	16	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	16	16	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	16	16	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	16	16	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	16	16	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	16	16	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	16	16	100.0%
Member required a Risk Management Agreement.*[1]	8	16	50.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	8	12.5%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	14	16	87.5%

Member required a PCA reassessment due to changes in condition.*[1,2]	7	14	50.0%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	6	7	85.7%
Member experienced issues that impeded access to care.*	2	25	8.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	2	2	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	20	25	80.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	7	25	28.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	7	7	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	7	25	28.0%
Member refused the ten (10) business day post discharge onsite visit.*	1	7	14.3%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	1	1	100.0%
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	6	6	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	7	7	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	12	25	48.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	12	12	100.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	10	12	83.3%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	10	10	100.0%
Member had a change in placement during the review period.*	9	25	36.0%

Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	9	9	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
[2]Denominator includes all Members with PCA services (self-directed or agency) prior to MLTSS enrollment and total PCA assessments completed during the review period.
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	16	16	100.0%
Member reported a gap in service delivery.*[1]	1	16	6.3%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	1	0.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 50 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were no files excluded. The Member Outreach category is not assessed for Members in Group E. All 50 files were reviewed for compliance in 5 categories. There were 19 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The annual NJ Choice Assessment (NJCA) was due during the review period.*	47	50	94.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	47	47	100.0%
NJCA to reassess clinical eligibility for MLTSS was completed within 11 to 13 months from the last NJCA authorized by OCCO.	47	47	100.0%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	50	50	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	0	0	N/A

MCO completed Options Counseling with the Member or authorized representative.	47	47	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.[1]	0	35	0.0%
Member had PPP services in place prior to the review period. *[2]	8	31	25.8%
Member was offered the participant direction option during Options Counseling.[2]	21	23	91.3%
Member chose the participant direction option.*[2]	2	21	9.5%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	1	2	50.0%
Member had PCA services through an agency in place prior to review period.*[2]	10	19	52.6%
Member refused PCA services through an agency.*[2]	4	9	44.4%
MCO completed a PCA assessment with the Member during the review period.[2,3]	6	7	85.7%
A cost effective analysis (CEA) was completed during the review period.	42	50	84.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	2	42	4.8%
Member's annual cost threshold (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	2	0.0%

*Not included in aggregate score calculation

[1]Denominator excludes 12 Members where OCCO completed a NJCA secondary review.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	47	47	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress	50	50	100.0%

documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).			
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	31	31	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	31	31	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	31	31	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	31	31	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	31	31	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	31	31	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	50	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Care Manager completed an annual risk assessment for the Member.[1]	30	31	96.8%
Members who were identified as having a positive risk.*[1]	6	30	20.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.*[1]	19	24	79.2%
The MCO appropriately determined the Member had no potential risks during the review period.[2]	5	24	20.8%
Members who were identified as having a positive risk had a signed Risk Management Agreement with all components.[1]	6	6	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Rate is calculated by the number of "No" determinations divided by the sum of the "Yes" plus "No" determinations.

Ongoing Care Management	**N**	**D**	**Rate**
Member required a PCA reassessment due to changes in condition.*[1,2]	16	24	66.7%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	16	16	100.0%
Member experienced issues that impeded access to care.*	4	50	8.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	3	4	75.0%

Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	48	50	96.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	32	50	64.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	32	32	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	13	50	26.0%
Member refused the ten (10) business day post discharge onsite visit.*	2	13	15.4%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	2	2	100.0%
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	9	11	81.8%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	13	13	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	33	50	66.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	32	33	97.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	32	33	97.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	32	32	100.0%
Member had a change in placement during the review period.*	21	50	42.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	21	21	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to the review period and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	31	31	100.0%
Member reported a gap in service delivery.*[1]	1	31	3.2%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Overall, HNJH's audit results ranged from 96.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	25	25	100.0%
	Group D	23	25	92.0%
	Group E[4]			
	Total	48	50	96.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	47	47	100.0%
	Total	47	47	100.0%

#9a Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	4	4	100.0%
	Group D	12	12	100.0%
	Group E	32	33	97.0%
	Total	48	49	98.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice Assessment.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	15	15	100.0%
	Group D	16	16	100.0%
	Group E	31	31	100.0%
	Total	62	62	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]Members who did not have a documented change in condition during the study period are excluded from this measure.
[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4]Group E Members are excluded from this measure as they are not new to MLTSS.
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.

Discussion

Limitations

None

Conclusions and Recommendations

Population-Specific conclusions, along with opportunities for improvement, are presented by category below. Recommendations are based on deficiencies identified at the group level (Groups C, D, and E).

Assessment

Across all three groups, the MCO had a combined score of 98.8% in the Assessment category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	95.8%
Group E	100.0%
Combined	98.8%

Member Outreach

Across groups, the MCO had a combined score of 88.0% in the Member Outreach category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	76.0%
Group E[1]	--
Combined	88.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group D:** HNJH should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 75.8% in the Face-to-Face Visits category.

Group	7/1/24 to 6/30/25
Group C	77.8%
Group D	80.9%
Group E	70.5%
Combined	75.6%

Opportunities for Improvement for elements at the group level in the *Face-to-Face Visits* category include the following:

- **Group C, Group D, and Group E:** HNJH should ensure that the Options Counseling Summary form is mailed to the Member within 5 business days of OCCO determination.

Group E:

- For Members who selected the participant direction option, HNJH should ensure that the application packages were submitted within thirty (30) business days of completion.
- For Members who selected PCA services (self-directed or agency) during the review period, HNJH should ensure that a PCA assessment is completed with the Member.
- HNJH should ensure that a cost effective analysis (CEA) is completed with the Member during the review period.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 97.7% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/24 to 6/30/25
Group C	99.7%
Group D	97.2%
Group E	97.1%
Combined	97.7%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 96.6% in the Ongoing Care Management category.

Group	7/1/24 to 6/30/25
Group C	98.9%
Group D	92.8%
Group E	97.6%
Combined	96.6%

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 99.4% in the Gaps in Care/Critical Incidents category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	97.6%
Group E	100.0%
Combined	99.4%

Performance Measures

Overall, the MCO scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2025 Annual Assessment Review of Care Management
Horizon New Jersey Health

Review Period - July 1, 2024 to June 30, 2025

January 2026

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Introduction

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Background

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jerey Health (HNJH) as evidence of compliance of the standards under review; interviews with key HNJH staff (held via Teams meeting on December 10, 2025) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on August 22, 2025, and received from the MCOs on September 12, 2025. The documentation review occurred offsite at IPRO beginning on September 15, 2025. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2024 to June 30, 2025. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore are considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2025 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. HNJH received an overall compliance score of 100% in 2025. In 2024, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

Appendix E – UHCCP 2025 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
UnitedHealthcare Community Plan

Review Period: January 1, 2024 to December 31, 2024

September 2025

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

MCO Care Management Chart Audit

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant Enrollees from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 390 cases for UnitedHealthcare Community Plan (UHCCP).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees (including a 30% oversample required for substitutions or exclusions) was selected for the General, DDD, and DCP&P Populations. If the MCO's sample did not meet the sample size of 130 for each individual population, the entire population was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible new and existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL).	Capitation Codes 17399, 37399, 57599, 59199, 87399, and 99499.	Capitation Codes 49499 or 81299 ***OR*** PSC 600 and County Code less than 22. ***AND*** (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499).
	IPRO will pull a random sample from the universes provided as follows: 1) 65 Enrollees new to the MCO and Care Management anytime from 1/1/2024 through 11/16/2024 ***AND*** 2) 65 existing Enrollees new to Care Management from 3/1/2024 through 11/16/2024 from the universes provided.*	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DDD Enrollees in Care Management ***AND*** 2) ALL existing eligible DDD Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DDD Enrollees in Care	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DCP&P Enrollees in Care Management ***AND*** 2) ALL existing eligible DCP&P Enrollees in Care Management. IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management

	*Random sample size modified by IPRO.	Management per MCO from the universes provided.* *Random sample size modified by IPRO.	per MCO from the universes provided.* *Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2024	>= 6 months as of 12/31/2024	>= 6 months and < 18 years as of 12/31/2024
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024
• Existing Enrollees	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024
Current Enrollment	Enrolled as of 12/31/2024 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2024 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.

Introductory E-Mail

For this year's chart audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year's audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's secure S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted file reviews over a five-week period. Inter-rater reliability was maintained through the use of a standardized Audit Tool, along with ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite chart audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's 2025 CM Audit results for the review period 1/01/2024 to 12/31/2024 ranged from 93.3% to 100.0% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=100)
Identification[1]	95.7%		
Outreach[2,3]	100.0%	100.0%	N/A[4]
Preventive Services[3]	100.0%	98.4%	93.3%
Continuity of Care[3]	99.7%	99.1%	99.8%
Coordination of Services[3]	99.7%	99.7%	100.0%

[1]The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.
[4]N/A: Not Applicable. No DCP&P Enrollees met criteria for this measure as all CNAs were completed timely.

General Population Findings

A combined total of 108 files were reviewed for the new and existing General Population. There were 8 files excluded from the analysis due to TPL or they did not meet the Care Management enrollment criteria for the review period. The remaining 100 files were assessed for compliance across the following five categories.

Identification

The Identification category applies to GP Enrollees (50) new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024. The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.

Table 3: Identification – General Population - Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2024 to 12/31/2024).*	50	50	100.0%
IHS was completed for the Enrollee within 45 days of MCO enrollment date.*	49	50	98.0%
For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date.	0	1	0.0%

Identification	General Population		
	Numerator	Denominator	Rate
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	22	22	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	50	50	100.0%	50	50	100.0%
MCO completed the CNA timely (within 30 days from IHS score of 5 or greater or from date of identification of CM needs).*	49	50	98.0%	49	50	98.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs.[1]	1	1	100.0%	1	1	100.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 1 file with an untimely CNA for new GP Enrollees and 1 file with an untimely CNA for existing GP Enrollees.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 5: Preventive Services – General Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	11	13	84.6%	16	16	100.0%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	0	0	N/A
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	0	0	N/A

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).* [2]	9	10	90.0%	13	14	92.9%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	1	1	100.0%	1	1	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).* [2]	25	29	86.2%	29	29	100.0%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	4	4	100.0%	0	0	N/A
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	37	37	100.0%	34	34	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	8	11	72.7%	14	16	87.5%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	2	2	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	50	50	100.0%	50	50	100.0%
CNA was completed timely (within 30 days of identification of CM needs).	49	50	98.0%	49	50	98.0%
CNA contained all elements of the State approved CNA tool.	50	50	100.0%	50	50	100.0%
Care Manager documented a level of care for the Enrollee during the review period.	50	50	100.0%	50	50	100.0%
The Enrollee had a Care Plan on file during the review period.	50	50	100.0%	50	50	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	50	50	100.0%	50	50	100.0%
Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	50	50	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	50	50	100.0%	50	50	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	23	23	100.0%	23	23	100.0%

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	8	8	100.0%	2	2	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	8	8	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	50	50	100.0%	50	50	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	50	50	100.0%	50	50	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	50	50	100.0%	50	50	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	11	12	91.7%	9	9	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

A combined total of 108 files were reviewed for the new and existing DDD Population. There were 8 files excluded from the analysis due to TPL. The remaining 100 files were assessed for compliance in the following four categories.

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	41	50	82.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	39	41	95.1%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	11	11	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 2 files with untimely CNAs and 9 files without a CNA.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	18	25	72.0%	10	12	83.3%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	2	2	100.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	7	9	77.8%	8	10	80.0%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	2	2	100.0%	2	2	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	24	31	77.4%	31	34	91.2%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	7	7	100.0%	3	3	100.0%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	24	25	96.0%	37	38	97.4%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	11	25	44.0%	10	12	83.3%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	14	14	100.0%	2	2	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	14	14	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	41	50	82.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	39	41	95.1%			
CNA contained all elements of the State approved CNA tool.	41	41	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	41	41	100.0%	50	50	100.0%
The Enrollee had a Care Plan on file during the review period.	50	50	100.0%	50	50	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	41	41	100.0%			
Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	49	50	98.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	50	50	100.0%	49	50	98.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	26	26	100.0%	16	16	100.0%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	4	4	100.0%	5	5	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	3	4	75.0%	5	5	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2024 review period.

Table 11: Coordination of Services – DDD Population - New and Existing Enrollees in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	50	50	100.0%	50	50	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	44	44	100.0%	46	46	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	44	44	100.0%	46	46	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	2	3	66.7%	6	6	100.0%
For Enrollees hospitalized with a mental/behavioral health diagnosis, the Care Manager made aggressive outreach attempts to determine follow-up status with a mental/behavioral health provider.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

A combined total of 100 files were reviewed between the new and existing DCP&P Population. No files were excluded from the analysis. A total of 100 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DCP&P Enrollees (21) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population - Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	21	21	100.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	21	21	100.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file.

N/A: Not Applicable.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (21) and existing DCP&P Enrollees (79) in Care Management during the 2024 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	21	21	100.0%	75	79	94.9%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	4	4	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	3	4	75.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	19	20	95.0%	76	77	98.7%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	1	1	100.0%	1	1	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	12	15	80.0%	72	79	91.1%
Appropriate outreach attempts were documented to confirm dental status for	3	3	100.0%	7	7	100.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollees without a confirmed dental visit (aged 1 through 20).						
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	2	3	66.7%	7	7	100.0%

**Not Included in aggregate score calculation*
[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment
[2]Denominator excludes Enrollees or legal guardians who refused immunizations.
N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (21) and existing DCP&P Enrollees (79) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	21	21	100.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	21	21	100.0%			
CNA contained all elements of the State approved CNA tool.	21	21	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	21	21	100.0%	79	79	100.0%
The Enrollee had a Care Plan on file during the review period.	21	21	100.0%	79	79	100.0%
Care Plan was developed within 30 days of CNA completion.[1]	21	21	100.0%			
Care Plan was completed for the Enrollee that included all required components.	21	21	100.0%	79	79	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	21	21	100.0%	79	79	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	12	12	100.0%	46	47	97.9%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	2	2	100.0%	9	9	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	2	2	100.0%	9	9	100.0%

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (21) and existing DCP&P Enrollees (79) in Care Management during the 2024 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	21	21	100.0%	79	79	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	18	18	100.0%	76	76	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	20	20	100.0%	78	78	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	3	3	100.0%	8	8	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

Limitations

Rates with a denominator of less than 30 are not statistically significant and should be considered cautiously.

Conclusions

Overall, the MCO scored 85% or above in all review categories (**Table 2**):

- Identification (General Population) (95.7%)

- Outreach (General Population) (100.0%)
- Outreach (DDD Population) (100.0%)

- Preventive Services (General Population) (100.0%)
- Preventive Services (DDD Population) (98.4%)
- Preventive Services (DCP&P Population) (93.3%)

- Continuity of Care (General Population) (99.7%)
- Continuity of Care (DDD Population) (99.3%)
- Continuity of Care (DCP&P Population) (99.8%)

- Coordination of Services (General Population) (99.7%)
- Coordination of Services (DDD Population) (100.0%)
- Coordination of Services (DCP&P Population) (100.0%)

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by UnitedHealthcare Community Plan (UHCCP), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key UHCCP staff via TEAMS held on July 17, 2025, and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 7, 2025, and submissions were received from the MCOs on April 4, 2025. The documentation review occurred offsite at IPRO beginning on April 7, 2025. The audit review team was made up of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2024 to December 31, 2024.

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

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A – Not Applicable	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. UHCCP received an overall compliance score of 87% in 2025. In 2024, the MCO received a score of 90%. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Where appropriate, assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2024 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of UHCCP's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	X	-	X	-	-	-	X
CM3	X	X	-	-	-	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	X	-	-	-	X	-
CM8	X	X	-	-	-	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM17	X	-	X	-	-	-	X
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	X	X	-	-	-	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	27	26	4	0	2	1	2
Compliance Percentage		87%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 66.7% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 0.0% - For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days of the Enrollee's MCO enrollment date (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 75.0% - The Care Manager sent EPSDT reminders (applies to existing Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 66.7% - Care Manager sent dental reminders to Enrollees without a confirmed dental visit (applies to new Enrollees aged 1 through 20).
CM17	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 75.0% - The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs assessment tool.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: For an IHS not completed timely or no IHS on file, UHCCP should ensure that aggressive outreach attempts are performed and documented within 45 days from Enrollee's MCO enrollment date (applies to new Enrollees).

For the DDD Population:

1. CM2: For Enrollees who are hospitalized, UHCCP should ensure that adequate discharge planning is performed (applies to new Enrollees).
2. CM17: For Enrollees with a comprehensive treatment plan, UHCCP should ensure the treatment plan progresses in a timely manner without unreasonable interruption (applies to new Enrollees).

For the DCP&P Population:

1. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, UHCCP should ensure EPSDT reminders are sent (applies to existing Enrollees).
2. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, UHCCP should ensure dental reminders are sent (applies to new Enrollees).

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
UnitedHealthcare Community Plan

Review Period July 1, 2024 – June 30, 2025

February 2026

Better healthcare, realized.

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Managed Care Contract (Article 9). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 120 cases for UnitedHealthcare Community Plan (UHCCP) including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet

eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, along with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 120 cases selected for UHCCP, 114 Member files were reviewed and 100 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	28	27	59	114
Exclusions	3	2	9	14
Number of Files Included in Results	25	25	50	100

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's audit results for the combined MLTSS sample ranged from 30.0% to 96.7% across all three (3) subgroups for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2024 – June 30, 2025			
	Group C	Group D	Group E	Combined[3]
Assessment	100.0%	97.4%	94.9%	96.3%
Member Outreach[1]	24.0%	36.0%	--	30.0%
Face-to-Face Visits	74.8%	67.4%	70.2%	71.0%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[2]	88.4%	91.2%	94.3%	92.2%
Ongoing Care Management	75.3%	82.4%	75.8%	77.3%
Gaps in Care/Critical Incidents	95.2%	91.8%	100.0%	96.7%

[1]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[2]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 28 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 3 files excluded. All 25 files were further reviewed for compliance in 6 categories. There were 8 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested the NJ Choice Assessment (NJCA) for the Member from the Office of Community Choice Options (OCCO).*	0	25	0.0%
MCO requested the NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting an NJCA from OCCO).*	0	0	N/A
OCCO response was received within 5 business days of the MCO request.*	0	0	N/A
The MCO received the NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	0	N/A
OCCO completed the NJCA which was valid during the review period.*	0	25	0.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%

*Not included in aggregate score calculation.

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	6	25	24.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	22	25	88.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	3	3	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	3	3	100.0%
MCO completed Options Counseling with the Member or authorized representative.[1]	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	1	25	4.0%
Member was offered the participant direction option during Options Counseling.[2]	17	17	100.0%
Member chose the participant direction option.*[2]	6	17	35.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	3	6	50.0%
Member refused PCA services through an agency.*	5	11	45.5%
PCA assessment was completed with the Member during the review period.[2,3]	12	12	100.0%
PCA assessment was completed with the Member within 45 days of MLTSS enrollment.	11	12	91.7%
A cost effective analysis (CEA) was completed during the review period.	23	25	92.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	1	23	4.3%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	1	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	11	24	45.8%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	24	24	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	24	25	96.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	24	24	100.0%
Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	24	24	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	24	24	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	24	24	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	14	17	82.4%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	14	14	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	14	14	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	14	14	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	8	14	57.1%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	17	17	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	19	25	76.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	24	25	96.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	17	17	100.0%
Member required a Risk Management Agreement.*[1]	17	17	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	9	17	52.9%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	17	17	100.0%
Member required a PCA reassessment due to changes in condition.*[1,2]	4	12	33.3%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	3	4	75.0%

Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	25	25	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	9	25	36.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	3	25	12.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	1	3	33.3%
Member file indicates disagreement with the Plan of Care.*	0	2	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	5	25	20.0%
Member refused the ten (10) business day post discharge onsite visit.*	2	5	40.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	1	2	50.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) business days of discharge.	3	3	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	5	5	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	2	25	8.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	1	2	50.0%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	1	2	50.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	1	1	100.0%
Member had a change in placement during the review period.*	0	25	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Member receiving MLTSS services and not residing in community alternative residential setting (CARS) during the review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	17	17	100.0%
Member reported a gap in service delivery.*[1]	0	17	0.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	23	25	92.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 27 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were 2 files excluded. All 25 files were further reviewed for compliance in all 6 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	13	25	52.0%
The MCO completed the NJCA with the Member during the review period.	24	25	96.0%
NJCA was completed within 30 days of a referral to MLTSS.	13	13	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	9	25	36.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	23	25	92.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	2	2	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	2	2	100.0%
MCO completed Options Counseling with the Member or authorized representative.	24	24	100.0%

Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	0	24	0.0%
Member had PPP services in place prior to MLTSS enrollment.*	6	25	24.0%
Member was offered the participant direction option during Options Counseling.[1]	19	19	100.0%
Member chose the participant direction option.*[1]	0	19	0.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	0	0	N/A
Member had PCA services through an agency in place prior to MLTSS enrollment.*	14	19	73.7%
Member refused PCA services through an agency.*[1]	5	5	100.0%
PCA assessment was completed with the Member during the review period.[1,2]	0	0	N/A
PCA assessment completed with the Member within 45 days of MLTSS enrollment.[1]	0	0	N/A
A cost effective analysis (CEA) was completed during the review period.	21	25	84.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	3	21	14.3%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	3	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	9	25	36.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	23	23	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	22	25	88.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	22	22	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	23	23	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	23	23	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the	23	23	100.0%

Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.			
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	21	23	91.3%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	21	21	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	21	21	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	21	21	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	15	21	71.4%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	21	23	91.3%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	21	25	84.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	23	25	92.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	23	23	100.0%
Member required a Risk Management Agreement.*[1]	21	23	91.3%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	21	21	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	22	23	95.7%
Member required a PCA reassessment due to changes in condition.*[1,2]	0	20	0.0%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	0	0	N/A
Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	23	25	92.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	12	23	52.2%

Member required a change in Plan of Care based on an increase or reduction of services.*	3	25	12.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	2	3	66.7%
Member file indicates disagreement with the Plan of Care.*	1	1	100.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	1	1	100.0%
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	3	25	12.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	3	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	3	3	100.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	3	3	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	3	25	12.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	2	3	66.7%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	3	3	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	3	3	100.0%
Member had a change in placement during the review period.*	1	25	4.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to MLTSS enrollment and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	21	23	91.3%
Member reported a gap in service delivery.*[1]	1	23	4.3%

Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	23	25	92.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 59 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 9 files excluded. The Member Outreach category is not assessed for Members in Group E. All 50 files were reviewed for compliance in 5 categories. There were 8 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The annual NJ Choice Assessment (NJCA) was due during the review period.*	49	50	98.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	49	49	100.0%
NJCA to reassess clinical eligibility for MLTSS was completed within 11 to 13 months from the last NJCA authorized by OCCO.	44	49	89.8%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	44	50	88.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	6	6	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	6	6	100.0%
MCO completed Options Counseling with the Member or authorized representative.	44	49	89.8%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.[1]	0	42	0.0%
Member had PPP services in place prior to the review period. *[2]	14	42	33.3%
Member was offered the participant direction option during Options Counseling.[2]	28	28	100.0%
Member chose the participant direction option.*[2]	0	28	0.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	0	0	N/A
Member had PCA services through an agency in place prior to review period.*[2]	19	28	67.9%
Member refused PCA services through an agency.*[2]	11	12	91.7%
MCO completed a PCA assessment with the Member during the review period.[2,3]	1	1	100.0%

A cost effective analysis (CEA) was completed during the review period.	47	50	94.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	1	47	2.1%
Member's annual cost threshold (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	1	0.0%

*Not included in aggregate score calculation

[1]Denominator excludes 2 Members where OCCO completed a NJCA secondary review.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	**N**	**D**	**Rate**
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	45	49	91.8%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	50	50	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	40	42	95.2%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	40	40	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	40	40	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	40	40	100.0%

Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	25	40	62.5%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	42	42	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	40	50	80.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Care Manager completed an annual risk assessment for the Member.[1]	41	42	97.6%
Members who were identified as having a positive risk.*[1]	39	41	95.1%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.*[1]	1	2	50.0%
The MCO appropriately determined the Member had no potential risks during the review period.[2]	1	2	50.0%
Members who were identified as having a positive risk had a signed Risk Management Agreement with all components.[1]	28	39	71.8%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Rate is calculated by the number of "No" determinations divided by the sum of the "Yes" plus "No" determinations.

Ongoing Care Management	N	D	Rate
Member required a PCA reassessment due to changes in condition.*[1,2]	13	34	38.2%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	11	13	84.6%
Member experienced issues that impeded access to care.*	0	50	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	18	50	36.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	11	50	22.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	9	11	81.8%
Member file indicated a disagreement with the Plan of Care.*	0	2	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	21	50	42.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	21	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	13	21	61.9%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	20	21	95.2%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	13	50	26.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	11	13	84.6%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	12	13	92.3%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	12	12	100.0%
Member had a change in placement during the review period.*	3	50	6.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	1	3	33.3%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to the review period and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	42	42	100.0%
Member reported a gap in service delivery.*[1]	1	42	2.4%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Overall, UHCCP's audit results ranged from 40.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	11	25	44.0%
	Group D	9	25	36.0%
	Group E[4]			
	Total	20	50	40.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	45	49	91.8%
	Total	45	49	91.8%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	1	2	50.0%
	Group D	2	3	66.7%
	Group E	11	13	84.6%
	Total	14	18	77.8%
#10. Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice Assessment.	Group C	24	24	100.0%
	Group D	22	22	100.0%
	Group E	50	50	100.0%
	Total	96	96	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	24	24	100.0%
	Group D	23	23	100.0%

	Group E	50	50	100.0%
	Total	97	97	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	14	17	82.4%
	Group D	21	23	91.3%
	Group E	40	42	95.2%
	Total	75	82	91.5%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	23	25	92.0%
	Group D	23	25	92.0%
	Group E	50	50	100.0%
	Total	96	100	96.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]Members who did not have a documented change in condition during the study period are excluded from this measure.
[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4]Group E Members are excluded from this measure as they are not new to MLTSS.
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.

Discussion

Limitations

None

Conclusions and Recommendations

Population-Specific conclusions, along with opportunities for improvement, are presented by category below. Recommendations are based on deficiencies identified at the group level (Groups C, D, and E).

Assessment

Across all three groups, the MCO had a combined score of 96.3% in the Assessment category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	97.4%
Group E	94.9%
Combined	96.3%

Member Outreach

Across groups, the MCO had a combined score of 30.0% in the Member Outreach category.

Group	7/1/24 to 6/30/25
Group C	24.0%
Group D	36.0%
Group E[1]	--
Combined	30.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group C and Group D:** UHCCP should ensure that initial outreach to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) is completed within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 71.0% in the Face-to-Face Visits category.

Group	7/1/24 to 6/30/25
Group C	74.8%
Group D	67.4%
Group E	70.2%
Combined	71.0%

Opportunities for Improvement for elements at the group level in the *Face-to-Face Visits* category include the following:

- **Group C, D and E:** UHCCP should ensure that the Options Counseling Summary form is mailed to the Member within (5) business days of OCCO determination.
- **Group C:** UHCCP should ensure for Members who select the participant direction option, application packages are completed and submitted within thirty (30) business days of completion.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 92.2% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/24 to 6/30/25
Group C	88.4%
Group D	91.2%
Group E	94.3%
Combined	92.2%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 77.3% in the Ongoing Care Management category.

Group	7/1/24 to 6/30/25
Group C	75.3%
Group D	82.4%
Group E	75.8%
Combined	77.3%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

Group C and Group E:

- UHCCP should ensure a PCA reassessment is conducted for Members that require a PCA assessment due to a change in condition.

- UHCCP should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- For Members who are discharged to an HCBS setting, UHCCP should ensure the onsite review occurs within ten (10) business days of discharge.

Group C, Group D and Group E:

- UHCCP should ensure that for Members whose files indicate a change from the Initial Plan of Care, the Member's Plan of Care is updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signs and is provided with a copy of the Plan of Care.

- For Members with a change in condition, UHCCP should ensure that the Member's Plan of Care is amended, reviewed, and signed by the Member and/or authorized representative.

- **Group C**: For Members with a significant change in condition, UHCCP should ensure a functional need (NJCA) reassessment is completed. .

- **Group E:** For Members that have a change in placement indicated, there is documentation of discussion with the Member before the change is made.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 96.7% in the Gaps in Care/Critical Incidents category.

Group	7/1/24 to 6/30/25
Group C	95.2%
Group D	91.8%
Group E	100.0%
Combined	96.7%

Performance Measures

Overall, the MCO scored below 86% in two (2) Performance Measures of the seven (7) Performance Measures.

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- **Group C and Group D:** UHCCP should ensure that the Initial Plan of Care is completed, signed, and mailed within 45 days of MLTSS enrollment.

- **PM #9a:** Plan of Care for MLTSS Members amended based on change of Member condition.

  - **Group C, Group D and Group E:** For MLTSS Members with a change in condition, UHCCP should ensure that the Plan of Care is amended to reflect the changes in Member condition.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2025 Annual Assessment Review of Care Management
UnitedHealthcare Community Plan

Review Period - July 1, 2024 to June 30, 2025

January 2026

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Introduction

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Background

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standards under review; interviews with key UHCCP staff (held via Teams meeting on December 10, 2025) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on August 22, 2025, and received from the MCOs on September 12, 2025. The documentation review occurred offsite at IPRO beginning on September 15, 2025. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2024 to June 30, 2025. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore are considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2025 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. UHCCP received an overall compliance score of 100% in 2025. In 2024, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

Appendix F – WPNJ 2025 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Wellpoint New Jersey, Inc.

Review Period: January 1, 2024 to December 31, 2024

September 2025

Corporate Headquarters
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ipro.org

ISO 9001:2015 CERTIFIED

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment is to evaluate the effectiveness of the Care Management (CM) program as mandated by contractual requirements. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), has established Care Management standards to ensure that services delivered to Enrollees with special health care needs align with professionally recognized standards of care.

The Care Management Chart Audit and Annual Assessment encompassed two distinct review components: a chart review and an evaluation of documentation related to Care Management elements. IPRO conducted this comprehensive assessment across three defined Enrollee populations—General Population (GP), individuals enrolled through the Division of Developmental Disabilities (DDD), and those served by the Division of Child Protection and Permanency (DCP&P).

Each year, DMAHS evaluates Managed Care Organization (MCO) compliance with these requirements through its External Quality Review Organization (EQRO) contractor, using the audit and assessment results to drive performance improvements.

MCO Care Management Chart Audit

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract (Article 4) and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the New Jersey FamilyCare Contract references, NJ Care Management Workbook, CDC Immunization Schedules, and prior year's report. For the General Population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024; and existing Enrollees enrolled in Care Management between 3/1/2024 and 11/16/2024. For the DDD and DCP&P Populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2024 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2024. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a

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

IPRO prepared audit tools structured to collect requirement-specific information related to Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant Enrollees from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 390 cases for Wellpoint New Jersey, Inc. (WPNJ).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees (including a 30% oversample required for substitutions or exclusions) was selected for the General, DDD, and DCP&P Populations. If the MCO's sample did not meet the sample size of 130 for each individual population, the entire population was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible new and existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL).	Capitation Codes 17399, 37399, 57599, 59199, 87399, and 99499.	Capitation Codes 49499 or 81299 ***OR*** PSC 600 and County Code less than 22. ***AND*** (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499).
	IPRO will pull a random sample from the universes provided as follows: 1) 65 Enrollees new to the MCO and Care Management anytime from 1/1/2024 through 11/16/2024 ***AND***	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DDD Enrollees in Care Management ***AND*** 2) ALL existing eligible DDD Enrollees in Care Management.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (excluding TPL) for: 1) ALL newly eligible DCP&P Enrollees in Care Management ***AND*** 2) ALL existing eligible DCP&P Enrollees in Care Management.

	2) 65 existing Enrollees new to Care Management from 3/1/2024 through 11/16/2024 from the universes provided.* * Random sample size modified by IPRO.	IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.* * Random sample size modified by IPRO.	IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.* * Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2024	>= 6 months as of 12/31/2024	>= 6 months and < 18 years as of 12/31/2024
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024	Initial enrollment from 1/1/2024 through 7/1/2024
• Existing Enrollees	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024	Enrolled prior to 1/1/2024
Current Enrollment	Enrolled as of 12/31/2024 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/24 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2024 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2024 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2024 the later MCO enrollment is selected.

Introductory E-Mail

For this year's chart audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year's audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's secure S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted file reviews over a five-week period. Inter-rater reliability was maintained through the use of a standardized Audit Tool, along with ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite chart audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WPNJ's 2025 CM Audit results for the review period 1/01/2024 to 12/31/2024 ranged from 72.0% to 100.0% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=72)	DDD (n=100)	DCP&P (n=30)
Identification[1]	98.1%		
Outreach[2,3]	72.0%	100.0%	N/A[4]
Preventive Services[3]	95.1%	83.5%	100.0%
Continuity of Care[3]	94.2%	90.5%	99.0%
Coordination of Services[3]	99.1%	99.4%	93.3%

[1]The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of new and existing population specific rates.
[4]N/A: Not Applicable. No DCP&P Enrollees met criteria for this measure as all CNAs were completed timely.

General Population Findings

A combined total of 130 files were reviewed for the new and existing General Population. There were 58 files excluded from the analysis as they did not meet the Care Management enrollment criteria for the review period. The remaining 72 files were assessed for compliance across the following five categories.

Identification

The Identification category applies to GP Enrollees (46) new to the MCO and new to Care Management between 1/1/2024 and 11/16/2024. The Identification category is not evaluated for new and existing DDD and DCP&P Enrollees, or existing GP Enrollees.

Table 3: Identification – General Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2024 to 12/31/2024).*	24	46	52.2%
IHS was completed for the Enrollee within 45 days of MCO enrollment date.*	22	24	91.7%

Identification	General Population		
	Numerator	Denominator	Rate
For an IHS not completed timely or no IHS on file, aggressive outreach attempts were performed and documented within 45 days from the Enrollee's MCO enrollment date.	23	24	95.8%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	28	28	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (46) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (26) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	44	46	95.7%	17	26	65.4%
MCO completed the CNA timely (within 30 days from IHS score of 5 or greater, or from date of identification of CM needs).*	35	44	79.5%	17	17	100.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs.[1]	10	11	90.9%	3	9	33.3%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	3	3	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 9 files with untimely CNAs and 2 files without a CNA for new GP Enrollees, and 9 files without a CNA for existing GP Enrollees.

Preventative Services

The Preventive Services category applies to new GP Enrollees (46) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (26) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	13	16	81.3%	12	14	85.7%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	2	2	100.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	11	15	73.3%	7	14	50.0%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	4	4	100.0%	6	7	85.7%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	5	11	45.5%	3	7	42.9%
Appropriate outreach attempts were documented to confirm vaccination status for Enrollees (aged 19 and above).	6	6	100.0%	4	4	100.0%
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	30	30	100.0%	11	12	91.7%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	4	12	33.3%	5	12	41.7%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	6	7	85.7%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	5	7	71.4%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (46) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (26) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	44	46	95.7%	17	26	65.4%
CNA was completed timely (within 30 days of identification of CM needs).	35	44	79.5%	17	17	100.0%
CNA contained all elements of the State approved CNA tool.	44	44	100.0%	17	17	100.0%
Care Manager documented a level of care for the Enrollee during the review period.	44	44	100.0%	16	17	94.1%
The Enrollee had a Care Plan on file during the review period.	39	46	84.8%	20	26	76.9%
Care Plan was developed within 30 days of CNA completion.[1]	38	38	100.0%	16	16	100.0%
Care Plan was completed for the Enrollee that included all required components.	39	39	100.0%	19	20	95.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	39	39	100.0%	19	20	95.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	5	5	100.0%	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive	1	1	100.0%	0	0	N/A

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
treatment plan was documented to address the Enrollee's specific care needs.						
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (46) enrolled in Care Management between 1/1/2024 and 11/16/2024 and existing GP Enrollees (26) enrolled in Care Management between 3/1/2024 and 11/16/2024.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	7	7	100.0%	9	9	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	37	37	100.0%	14	14	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	14	14	100.0%	3	3	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	17	18	94.4%	8	8	100.0%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations

[4]DOH: Department of Health

DDD Population Findings

A combined total of 117 files were reviewed for the new and existing DDD Population. There were 17 files excluded from the analysis due to TPL. The remaining 100 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DDD Enrollees (20) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	20	20	100.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	17	20	85.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	3	3	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file. The denominator in this measure includes 3 files with untimely CNAs.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (20) and existing DDD Enrollees (80) in Care Management during the 2024 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	6	9	66.7%	14	16	87.5%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	2	2	100.0%
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	3	66.7%	1	2	50.0%
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	5	6	83.3%	6	10	60.0%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	1	1	100.0%	4	4	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*[2]	3	7	42.9%	27	52	51.9%
Appropriate outreach attempts were documented to confirm vaccination	4	4	100.0%	14	25	56.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
status for Enrollees (aged 19 and above).						
Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	11	11	100.0%	54	64	84.4%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	3	9	33.3%	12	16	75.0%
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	6	6	100.0%	4	4	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	6	6	100.0%	4	4	100.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations/vaccinations.

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (20) and existing DDD Enrollees (80) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	20	20	100.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	17	20	85.0%			
CNA contained all elements of the State approved CNA tool.	20	20	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	20	20	100.0%	43	80	53.8%
The Enrollee had a Care Plan on file during the review period.	20	20	100.0%	77	80	96.3%
Care Plan was developed within 30 days of CNA completion.[1]	20	20	100.0%			
Care Plan was completed for the Enrollee that included all required components.	20	20	100.0%	77	77	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	20	20	100.0%	77	77	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	1	1	100.0%	8	9	88.9%
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (20) and existing DDD Enrollees (80) in Care Management during the 2024 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	20	20	100.0%	79	80	98.8%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	5	5	100.0%	32	32	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	7	7	100.0%	20	20	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	2	2	100.0%	4	4	100.0%
For Enrollees hospitalized with a mental/behavioral health diagnosis, the Care Manager made aggressive outreach attempts to determine follow-up status with a mental/behavioral health provider.	1	1	100.0%	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

A combined total of 130 files were reviewed for the new and existing DCP&P Population. There were 100 files excluded from the analysis due to adoption, adoption subsidy, and interstate services. The remaining 30 files were assessed for compliance across the following four categories.

Outreach

The Outreach category applies to new DCP&P Enrollees (26) in Care Management during the 2024 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population - Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
MCO completed a CNA) during the review period.*	26	26	100.0%
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.*	26	26	100.0%
For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 45 days of MCO enrollment.[1]	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollee files with an untimely CNA or no CNA on file.
N/A: Not Applicable.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (26) and existing DCP&P Enrollees (4) in Care Management during the 2024 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule and confirmed by a reliable source (aged 0 through 20).*	26	26	100.0%	4	4	100.0%
Appropriate outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	0	N/A
Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	0	N/A
Enrollee's immunizations are up to date and confirmed by a reliable source (aged 0 through 18).*[2]	22	24	91.7%	3	4	75.0%
Appropriate outreach attempts were documented to confirm immunization status (aged 0 through 18).	2	2	100.0%	1	1	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	6	15	40.0%	2	4	50.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate outreach attempts were documented to confirm dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	9	9	100.0%	2	2	100.0%
Care Manager sent dental reminders to Enrollees without a confirmed dental visit (aged 1 through 20).	9	9	100.0%	2	2	100.0%

**Not Included in aggregate score calculation*

[1] EPSDT: Early and Periodic Screening, Diagnostic and Treatment

[2]Denominator excludes Enrollees or legal guardians who refused immunizations.

N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (26) and existing DCP&P Enrollees (4) in Care Management during the 2024 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
MCO completed a CNA during the review period.*	26	26	100.0%			
MCO completed the CNA timely, within 45 days from Enrollee's MCO enrollment date.	26	26	100.0%			
CNA contained all elements of the State approved CNA tool.	26	26	100.0%			
Care Manager documented a level of care for the Enrollee during the review period.	26	26	100.0%	3	4	75.0%
The Enrollee had a Care Plan on file during the review period.	26	26	100.0%	3	4	75.0%
Care Plan was developed within 30 days of CNA completion.[1]	26	26	100.0%			
Care Plan was completed for the Enrollee that included all required components.	26	26	100.0%	3	3	100.0%
Enrollee's Care Plan was reviewed/monitored during the review period. At a minimum annually.	26	26	100.0%	3	3	100.0%
For Enrollees with a change in care needs or circumstances during the review period, the Care Plan was updated to reflect those changes.	2	2	100.0%	0	0	N/A
For Enrollees demonstrating needs requiring a comprehensive treatment plan, a comprehensive treatment plan was documented to address the Enrollee's specific care needs.	1	1	100.0%	1	1	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	1	1	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollees with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (26) and existing DCP&P Enrollees (4) in Care Management during the 2024 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	24	26	92.3%	3	4	75.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	4	4	100.0%	3	3	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	3	3	100.0%	2	2	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	2	2	100.0%	1	1	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

Limitations

WPNJ had a combined total of 100 file exclusions for the DCP&P Population new and existing Enrollees. As a result, the total files assessed for compliance were 26 (new Enrollees) and 4 (existing Enrollees). Rates with a denominator of less than 30 are not statistically significant and should be considered cautiously.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Identification (General Population) (98.1%)
- Outreach (DDD Population) (100.0%)
- Preventive Services (General Population) (95.1%)
- Preventive Services (DCP&P Population) (100.0%)
- Continuity of Care (General Population) (94.2%)
- Continuity of Care (DDD Population) (90.5%)
- Continuity of Care (DCP&P Population) (99.0%)
- Coordination of Services (General Population) (99.1%)
- Coordination of Services (DDD Population) (99.4%)
- Coordination of Services (DCP&P Population) (93.3%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Outreach (General Population) (72.0%)
- Preventive Services (DDD Population) (83.5%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Wellpoint New Jersey, Inc. (WPNJ), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key WPNJ staff via TEAMS held on July 16, 2025, and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 7, 2025, and submissions were received from the MCOs on April 4, 2025. The documentation review occurred offsite at IPRO beginning on April 7, 2025. The audit review team was made up of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2024 to December 31, 2024.

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

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A – Not Applicable	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. WPNJ received an overall compliance score of 90% in 2025. In 2024, the MCO received a score of 73%. Review of the elements CM2, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2025. Where appropriate, assessment of certain elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2024 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	X	-	-	-	X	-
CM3	X	X	-	-	-	-	-
CM4	X	X	-	-	-	-	-
CM5	-	X	-	-	-	X	-
CM6	-	X	-	-	-	X	-
CM7	-	-	X	-	X	-	-
CM8	X	X	-	-	-	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	-	X	-	-	-	X	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	-	-	X	-	X	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	-	X	-	-	-	X	-
TOTAL	22	27	3	0	3	5	0
Compliance Percentage		90%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 33.3% - For CNAs not completed timely or no CNA on file, the MCO made aggressive efforts to complete within 30 days of identification of CM needs (applies to existing Enrollees). **In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 53.8% - The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees). **In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 75.0% - The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2025 CM file audit the MCO scored for the General Population Enrollees:** 71.4% - Care Manager sent dental reminders to Enrollees without a confirmed dental visit (applies to existing Enrollees aged 1 through 20). **In the 2025 CM file audit the MCO scored for the DDD Population Enrollees:** 66.7% - EPSDT reminders were sent (applies to new Enrollees aged 0 through 20 where EPSDT exam is not up to date). 50.0% - EPSDT reminders were sent (applies to existing Enrollees aged 0 through 20 where EPSDT exam is not up to date). 56.0% - Appropriate outreach attempts were documented to confirm vaccination status (applies to existing Enrollees aged 19 and above). 84.4% - Care Manager addressed and/or discussed dental needs (applies to existing Enrollees aged 21 and above).
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2025 CM file audit the MCO scored for the DCP&P Population Enrollees:** 75.0% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) (applies to existing Enrollees).

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.

Element	Contract Language
CM5	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.
CM37	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM7: For CNAs not completed timely or no CNA on file, WPNJ should ensure aggressive efforts are made to complete the CNA within 30 days of identification of CM needs (applies to existing Enrollees).
2. CM7 *File Audit:* WPNJ should ensure that a CNA is completed timely, within 30 days of identification of CM needs (applies to new Enrollees).
3. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees).
4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, WPNJ should ensure that dental reminders are sent (applies to existing Enrollees).

For the DDD Population:

1. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
2. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollee's EPSDT exam is not up to date (applies to new and existing Enrollees).
3. CM14: For Enrollees aged 19 and above, WPNJ should ensure appropriate outreach attempts are made to confirm vaccination status (applies to existing Enrollees).
4. CM14: For Enrollees aged 21 and above, WPNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees).

For the DCP&P Population:

1. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
2. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).
3. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).

Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Wellpoint New Jersey, Inc.

Review Period July 1, 2024 – June 30, 2025

February 2026

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2024 to June 30, 2025.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the January 2025 NJ FamilyCare Managed Care Contract (Article 9). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references. Effective July 1, 2023, at the direction of DMAHS, the audit methodology was revised to include an enhancement to MLTSS Performance Measure #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State produced (NJ Choice Assessment Data) list of MLTSS HCBS Members across all MCOs derived from the NJ Choice Assessment data *reason for assessment* code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS Member who appears to no longer meet NF level of care).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 120 cases for Wellpoint New Jersey, Inc. (WPNJ) including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2024 and 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2024 and 1/1/2025. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2025 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2024 and continuously enrolled in MLTSS through 6/30/2025.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2024. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2025 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C and D, and 60 Members for Group E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5, will be included in the base sample abstracted from the universe. All MLTSS Members were included if the MCO has less than 30 Members across subgroups C and D, or less than 60 Members for subgroup E who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 50 MLTSS HCBS Members across subgroups C and D, and 50 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample for each of the subgroups C, D, and E was drawn for substitution of exclusions.

MLTSS HCBS Members from subgroups C, D, and E abstracted for the Performance Measure #9a enhancement were included in the base sample abstraction.

All MLTSS HCBS Members were included if there were less than 50 Members across subgroups C and D, or less than 50 Members in subgroup E. Members could only be excluded by the MCO provided evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, along with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 120 cases selected for WPNJ, 103 Member files were reviewed and 100 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	25	26	52	103
Exclusions	0	1	2	3
Number of Files Included in Results	25	25	50	100

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WPNJ's audit results for the combined MLTSS sample ranged from 80.0% to 100.0% across all three (3) subgroups for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2024 – June 30, 2025			
	Group C	Group D	Group E	Combined[3]
Assessment	92.0%	100.0%	98.0%	97.7%
Member Outreach [1]	88.0%	72.0%	--	80.0%
Face-to-Face Visits	91.7%	82.1%	83.1%	85.2%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[2]	96.4%	95.1%	96.8%	96.3%
Ongoing Care Management	83.0%	84.8%	79.5%	81.2%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[2]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 25 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were no files excluded. All 25 files were further reviewed for compliance in 6 categories. There were 8 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested the NJ Choice Assessment (NJCA) for the Member from the Office of Community Choice Options (OCCO).*	2	25	8.0%
MCO requested the NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting an NJCA from OCCO).*	2	2	100.0%
OCCO response was received within 5 business days of the MCO request.*	2	2	100.0%
The MCO received the NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	2	0.0%
OCCO completed the NJCA which was valid during the review period.*	0	25	0.0%
The MCO completed the NJCA with the Member during the review period.	23	25	92.0%

*Not included in aggregate score calculation.

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	22	25	88.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	20	25	80.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	5	5	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	5	5	100.0%
MCO completed Options Counseling with the Member or authorized representative.[1]	23	23	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	15	23	65.2%
Member was offered the participant direction option during Options Counseling.[2]	15	15	100.0%
Member chose the participant direction option.*[2]	6	15	40.0%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[2]	7	7	100.0%
Member refused PCA services through an agency.*	2	9	22.2%
PCA assessment was completed with the Member during the review period.[2,3]	14	14	100.0%
PCA assessment was completed with the Member within 45 days of MLTSS enrollment.[2]	13	14	92.9%
A cost effective analysis (CEA) was completed during the review period.	24	25	96.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	24	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment.

[2]Denominator excludes Members residing in CARS.

[3]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	20	25	80.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	23	25	92.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	23	23	100.0%

Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	17	17	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	17	17	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	15	17	88.2%
Member service preference levels were documented in the Back-up Plan.[1]	16	17	94.1%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	14	17	82.4%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	17	17	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	17	17	100.0%
Member required a Risk Management Agreement.*[1]	17	17	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	16	17	94.1%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	16	17	94.1%
Member required a PCA reassessment due to changes in condition.*[1,2]	3	14	21.4%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	3	3	100.0%
Member experienced issues that impeded access to care.*	7	25	28.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	6	7	85.7%
Member had a documented face-to-face visit to review Member placement and services during the review period.	24	25	96.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	16	24	66.7%
Member required a change in Plan of Care based on an increase or reduction of services.*	8	25	32.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	5	8	62.5%
Member file indicates disagreement with the Plan of Care.*	0	3	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	5	25	20.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	5	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) business days of discharge.	3	5	60.0%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	5	5	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	0	25	0.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	0	0	N/A
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	0	0	N/A

Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	0	0	N/A
Member had a change in placement during the review period.*	0	25	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
[2]Denominator includes all Members with PCA services (self-directed or agency) and total PCA assessments completed during the review period.
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Member receiving MLTSS services and not residing in community alternative residential setting (CARS) during the review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	17	17	100.0%
Member reported a gap in service delivery.*[1]	0	17	0.0%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS.
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 26 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There was 1 file excluded. All 25 files were further reviewed for compliance in all 6 categories. There were 4 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	25	25	100.0%
The MCO completed the NJCA with the Member during the review period.	25	25	100.0%
NJCA was completed within 30 days of a referral to MLTSS.	25	25	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	18	25	72.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	24	25	96.0%
Member was unable to participate in a face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	1	1	100.0%
MCO completed Options Counseling with the Member or authorized representative.	25	25	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	4	25	16.0%
Member had PPP services in place prior to MLTSS enrollment.*	7	25	28.0%
Member was offered the participant direction option during Options Counseling.[1]	18	18	100.0%
Member chose the participant direction option.*[1]	6	18	33.3%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	6	6	100.0%
Member had PCA services through an agency in place prior to MLTSS enrollment.*	3	12	25.0%
Member refused PCA services through an agency.*[1]	6	9	66.7%
PCA assessment was completed with the Member during the review period.[1,2]	9	9	100.0%
PCA assessment completed with the Member within 45 days of MLTSS enrollment.[1]	9	9	100.0%
A cost effective analysis (CEA) was completed during the review period.	25	25	100.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	25	0.0%
Member's annual cost threshold (ACT) at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	18	25	72.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	25	25	100.0%
Plans of Care for MLTSS Members were aligned with Member's needs as identified during the NJCA.	24	25	96.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	21	21	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	21	21	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	15	21	71.4%
Member service preference levels were documented in the Back-up Plan.[1]	21	21	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	17	21	81.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	21	21	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	21	21	100.0%
Member required a Risk Management Agreement.*[1]	21	21	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	21	21	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	19	21	90.5%
Member required a PCA reassessment due to changes in condition.*[1,2]	7	19	36.8%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	7	7	100.0%
Member experienced issues that impeded access to care.*	5	25	20.0%

Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	5	5	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	24	25	96.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	13	24	54.2%
Member required a change in Plan of Care based on an increase or reduction of services.*	11	25	44.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	9	11	81.8%
Member file indicates disagreement with the Plan of Care.*	0	2	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	6	25	24.0%
Member refused the ten (10) business day post discharge onsite visit.*	0	6	0.0%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	5	6	83.3%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	5	6	83.3%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	8	25	32.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	7	8	87.5%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	8	8	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	7	8	87.5%
Member had a change in placement during the review period.*	3	25	12.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	3	3	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to MLTSS enrollment and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	21	21	100.0%
Member reported a gap in service delivery.*[1]	2	21	9.5%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 52 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 2 files excluded. The Member Outreach category is not assessed for Members in Group E. All 50 files were reviewed for compliance in 5 categories. There were 3 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The annual NJ Choice Assessment (NJCA) was due during the review period.*	49	50	98.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	49	49	100.0%
NJCA to reassess clinical eligibility for MLTSS was completed within 11 to 13 months from the last NJCA authorized by OCCO.	47	49	95.9%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	43	50	86.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	7	7	100.0%
Member or authorized representative participated in the face-to-face visit with the Care Manager.*	7	7	100.0%
MCO completed Options Counseling with the Member or authorized representative.	49	49	100.0%
Options Counseling Summary form was mailed to the Member within five (5) business days of OCCO determination.	18	49	36.7%
Member had PPP services in place prior to the review period.*[1]	14	47	29.8%
Member was offered the participant direction option during Options Counseling.[1]	33	33	100.0%

Member chose the participant direction option.*[1]	3	33	9.1%
For Members who selected the participant direction option, application packages were submitted within thirty (30) business days of completion.[1]	3	3	100.0%
Member had PCA services through an agency in place prior to review period.[1]*	26	30	86.7%
Member refused PCA services through an agency.*[1]	2	4	50.0%
MCO completed a PCA assessment with the Member during the review period.[1,2]	5	5	100.0%
A cost effective analysis (CEA) was completed during the review period.	49	50	98.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	49	0.0%
Member's annual cost threshold (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

[2]Denominator includes all Members who selected PCA Services (self-directed or agency) during the review period.

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	49	49	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	48	50	96.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	48	50	96.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%

Members who required a Back-up Plan had a completed and signed Back-up Plan using the State mandated form.[1]	47	47	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	47	47	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	38	47	80.9%
Member service preference levels were documented in the Back-up Plan.[1]	46	47	97.9%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	35	47	74.5%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	47	47	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	50	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Care Manager completed an annual risk assessment for the Member.[1]	47	47	100.0%
Members who were identified as having a positive risk.*[1]	47	47	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.*[1]	0	0	N/A
The MCO appropriately determined the Member had no potential risks during the review period.[2]	0	0	N/A
Members who were identified as having a positive risk had a signed Risk Management Agreement with all components.[1]	47	47	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Rate is calculated by the number of "No" determinations divided by the sum of the "Yes" plus "No" determinations.

N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member required a PCA reassessment due to changes in condition.*[1,2]	40	45	88.9%
MCO completed a PCA reassessment due to changes in Member's condition.[1]	36	40	90.0%
Member experienced issues that impeded access to care.*	15	50	30.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	13	15	86.7%
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	26	50	52.0%

Member required a change in Plan of Care based on an increase or reduction of services.*	40	50	80.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	20	40	50.0%
Member file indicated a disagreement with the Plan of Care.*	5	20	25.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	5	5	100.0%
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	32	50	64.0%
Member refused the ten (10) business day post discharge onsite visit.*	1	32	3.1%
Care Manager completed a post discharge telephonic visit within ten (10) business days of discharge to an HCBS setting.	1	1	100.0%
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) business days of discharge.	25	31	80.6%
Member was discharged to his/her own home and in-home services were in place in a timely manner.	29	32	90.6%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	44	50	88.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	31	44	70.5%
MCO completed a functional need (NJCA) reassessment as a result of Member's significant change in condition.	44	44	100.0%
Plan of Care was reviewed and revised as appropriate as a result of the reassessment of functional need (NJCA).	34	44	77.3%
Member had a change in placement during the review period.*	4	50	8.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	4	4	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS.

[2]Denominator includes all Members with PCA services (self-directed or agency) prior to the review period and total PCA assessments completed during the review period.

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	47	47	100.0%
Member reported a gap in service delivery.*[1]	7	47	14.9%
Members with a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	7	7	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS.

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Overall, WPNJ's audit results ranged from 73.1% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	20	25	80.0%
	Group D	18	25	72.0%
	Group E[4]			
	Total	38	50	76.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	49	49	100.0%

	Total	49	49	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition. [2]	Group C	0	0	N/A
	Group D	7	8	87.5%
	Group E	31	44	70.5%
	Total	38	52	73.1%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	23	23	100.0%
	Group D	24	25	96.0%
	Group E	48	50	96.0%
	Total	95	98	96.9%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan. [3]	Group C	17	17	100.0%
	Group D	21	21	100.0%
	Group E	47	47	100.0%
	Total	85	85	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	25	25	100.0%
	Group D	25	25	100.0%
	Group E	50	50	100.0%
	Total	100	100	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]Members who did not have a documented change in condition during the study period are excluded from this measure.
[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure.
[4]Group E Members are excluded from this measure as they are not new to MLTSS.
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.
N/A: Not Applicable. No Members in Group C met the criteria for this measure.

Discussion

Limitations

None

Conclusions and Recommendations

Population-Specific conclusions, along with opportunities for improvement, are presented by category below. Recommendations are based on deficiencies identified at the group level (Groups C, D, and E).

Assessment

Across all three groups, the MCO had a combined score of 97.7% in the Assessment category.

Group	7/1/24 to 6/30/25
Group C	92.0%
Group D	100.0%
Group E	98.0%
Combined	97.7%

Member Outreach

Across groups, the MCO had a combined score of 80.0% in the Member Outreach category.

Group	7/1/24 to 6/30/25
Group C	88.0%
Group D	72.0%
Group E[1]	--
Combined	80.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.

- **Group D:** WPNJ should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 85.2% in the Face-to-Face Visits category.

Group	7/1/24 to 6/30/25
Group C	91.7%
Group D	82.1%
Group E	83.1%
Combined	85.2%

Opportunities for Improvement for elements at the group level in the *Face-to-Face Visits* category include the following:

- **Group D and Group E**: WPNJ should ensure that the Options Counseling Summary form is mailed to the Member within (5) business days of OCCO determination.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 96.3% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/24 to 6/30/25
Group C	96.4%
Group D	95.1%
Group E	96.8%
Combined	96.3%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 81.2% in the Ongoing Care Management category.

Group	7/1/24 to 6/30/25
Group C	83.0%
Group D	84.8%
Group E	79.5%
Combined	81.2%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

Group C, Group D, and Group E:

- WPNJ should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- For Member files that indicate a change from the initial Plan of Care, WPNJ should ensure there is documentation that the Member's Plan of Care is updated and/or reviewed, Member agrees with the Plan of Care, Member signed the Plan of Care, and that a copy of the Plan of Care is provided to the Member.

- For Members who are discharged to an HCBS setting, WPNJ should ensure the onsite review occurs within ten (10) business days of discharge.

- **Group C:** WPNJ should ensure that for members with documented issues that impeded access to care, the Care Manager provides follow-up to resolve the issue.

- **Group D:** For Members discharged to his/her home, WPNJ should ensure that in-home services are in place in a timely manner.

Group E:

- For Member files that indicate a significant change in Member condition, WPNJ should ensure there is documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.

- WPNJ should ensure that the Plan of Care is reviewed and revised as appropriate as a result of a reassessment of functional need (NJCA).

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/24 to 6/30/25
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, the MCO scored below 86% in two (2) of the seven (7) Performance Measures.

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- **Group C and Group D:** WPNJ should ensure that the Initial Plan of Care is completed, signed, and mailed within 45 days of MLTSS enrollment.

PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.

- **Group E:** For MLTSS Members with a change in condition, WPNJ should ensure that the Plan of Care is amended to reflect the changes in Member condition.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2025 Annual Assessment Review of Care Management
Wellpoint New Jersey, Inc.

Review Period - July 1, 2024 to June 30, 2025

January 2026

Corporate Headquarters
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Introduction

The purpose of the 2025 Managed Long-Term Services and Supports (MLTSS) Annual Assessment Review of Care Management (CM) was to evaluate Managed Care Organization (MCO) compliance with the 2025 New Jersey FamilyCare MCO Contract and the effectiveness of the contractually required MLTSS CM program. CM elements for review were CM18b, CM28, CM29, CM30, CM31, CM32, CM34, CM36, CM37, and CM38 for the review period July 1, 2024 to June 30, 2025.

Background

The New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), have established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Wellpoint New Jersey, Inc. (WPNJ) as evidence of compliance of the standards under review; interviews with key WPNJ staff (held via Teams meeting on December 9, 2025) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on August 22, 2025, and received from the MCOs on September 12, 2025. The documentation review occurred offsite at IPRO beginning on September 15, 2025. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2024 to June 30, 2025. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore are considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2025 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. WPNJ received an overall compliance score of 100% in 2025. In 2024, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

Appendix G – 2025 Network Adequacy Provider Directory Validation Surveys

IPRO

Better healthcare, realized.

Aetna Better Health of New Jersey

2025 Provider Directory Validation Survey

Survey Period: August 2025 – September 2025

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2025, IPRO's evaluation included the NJ FamilyCare network for Aetna Better Health of New Jersey (ABHNJ).

Aim

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' method and scope of reporting practice site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

This report presents the findings of the 2025 Provider Directory Validation Survey for ABHNJ and includes a comparative analysis of 2024 and 2025 results to assess changes in network adequacy over time.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed ABHNJ's provider look-up system in August 2025 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.aetnabetterhealth.com/newjersey/find-provider
Website Access Date	8/4/2025-8/21/2025
Survey Date Range	8/11/2025-9/11/2025

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with ABHNJ.

A random sample totaling 350 providers was prepared for ABHNJ. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed ABHNJ's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

ABHNJ Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, ABHNJ achieved an overall provider directory access rate of 36.3% in 2025, marking an improvement from the previous year, with the highest compliance rate observed among dental and MLTSS providers (Table 3).

Table 2: Provider Directory Access Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	125	127
Access Rate	35.7%	36.3%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	57	28.5%
Pediatric Specialists	50	22	44.0%
Dental	50	24	48.0%
Managed Long-Term Services and Supports	50	24	48.0%
Total	**350**	**127**	**36.3%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	59	16.9%
Answering machine/Voice mail system	47	13.4%
Provider not a plan participant	32	9.1%
Provider not accepting new patients (closed panel)	21	6.0%
Constant busy signal	18	5.1%
Wrong telephone number	15	4.3%
Representative refuses to participate in audit	13	3.7%
Disconnected/Not in Service	12	3.4%
Not answered	8	2.3%
Provider practices a different specialty	7	2.0%
Total	**232**	

[1]Failure totals may include providers that have multiple failures.

[2] Failure rate is based on the total number of providers surveyed (350).

[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

ABHNJ Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with ABHNJ, their availability to accept new patients, their specialty type, and their telephone number and address. ABHNJ achieved an overall provider directory accuracy rate of 29.4% in 2025, marking an improvement from the previous year, with the highest compliance rate observed among dental and MLTSS providers.

Table 5: Provider Directory Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	99	103
Accuracy Rate	**28.3%**	**29.4%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	43	21.5%
Pediatric Specialists	50	12	24.0%
Dental	50	24	48.0%
Managed Long-Term Services and Supports	50	24	48.0%
Total	**350**	**103**	**29.4%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	59	16.9%
Answering machine/Voice mail system	47	13.4%
Provider not a plan participant	32	9.1%
Wrong address	32	9.1%
Provider not accepting new patients (closed panel)	21	6.0%
Constant busy signal	18	5.1%
Wrong telephone number	15	4.3%
Representative refuses to participate in audit	13	3.7%
Disconnected/Not in Service	12	3.4%
Not answered	8	2.3%
Provider practices a different specialty	7	16.9%
Total	**264**	

[1]Failure totals may include providers that have multiple failures.

[2] Failure rate is based on the total number of providers surveyed (350).

[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 220 had their board certification listed in the online provider directory. Among these providers, 39.5% positively confirmed their board certification status, reflecting an improvement compared to the 2024 board certification accuracy rate. The highest compliance rate was observed among pediatric specialists. There were no dental providers who reported board certification in the online provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Board Certification Listed[1]	221	220

	Measurement Year	
	2024	2025
Compliant Providers[2]	84	87
Compliance Rate	**38.0%**	**39.5%**

[1]Total Providers with board certification status listed in the online provider directory.

[2] Total number of providers with board certification status listed in the online provider directory and who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	147	60	40.8%
Pediatric Specialists	43	18	41.9%
Dental	0	N/A	N/A
Managed Long-Term Services and Supports	30	9	30.0%
Total	**220**	**87**	**39.5%**

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 64 had their disability access listed in the online provider directory. Among these providers, 56.3% positively confirmed disability access status, indicating a decline compared to the 2024 disability access accuracy rate. The highest compliance rate was observed among MLTSS providers.

Table 10: Provider Directory Disability Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Disability Access Listed[1]	57	64
Compliant Providers[2]	34	36
Compliance Rate	**59.6%**	**56.3%**

[1]Total Providers with disability access listed in the online provider directory.

[2] Total number of providers with disability access listed in the online directory and who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	7	5	71.4%
Pediatric Specialists	3	1	33.3%
Dental	50	26	52.0%
Managed Long-Term Services and Supports	4	4	100.0%
Total	**64**	**36**	**56.3%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of ABHNJ's online provider directory to assess how members are informed about a practice site's accessibility features. ABHNJ's online provider directory does have the ability to filter providers with accessibility features, but the degree of information is limited (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	No
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	No
Wheelchair ramps	No
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- ABHNJ should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. ABHNJ should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. This recommendation was also noted in 2024.
- ABHNJ should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory. This recommendation was also noted in 2024.
- ABHNJ should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. This recommendation was also noted in 2024.
- ABHNJ should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Opportunity for Improvement

- ABHNJ should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.

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Fidelis Care of New Jersey

2025 Provider Directory Validation Survey

Survey Period: August 2025 – September 2025

Prepared on behalf of:
The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2025, IPRO's evaluation included the NJ FamilyCare network for Fidelis Care of New Jersey (Fidelis Care).

Aim

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' method and scope of reporting practice site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

This report presents the findings of the 2025 Provider Directory Validation Survey for Fidelis Care and includes a comparative analysis of 2024 and 2025 results to assess changes in network adequacy over time.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed Fidelis Care's provider look-up system in August 2025 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://findaprovider.fideliscarenj.com/location
Website Access Dates	8/2/25-8/22/25
Survey Date Range	8/12/25-9/9/25

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with Fidelis Care.

A random sample totaling 350 providers was prepared for Fidelis Care. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed Fidelis Care's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

Fidelis Care Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, Fidelis Care achieved an overall provider directory access rate of 50.6% in 2025, closely aligned with the rate observed in 2024, with the highest compliance rate observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	176	177
Access Rate	50.3%	50.6%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	84	42.0%
Pediatric Specialists	50	35	70.0%
Dental	50	24	48.0%
Managed Long-Term Services and Supports	50	34	68.0%
Total	**350**	**177**	**50.6%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not a plan participant	57	16.3%
Provider not at site[3]	38	10.9%
Answering machine/Voice mail system	35	10.0%
Provider not accepting new patients (closed panel)	33	9.4%
Constant busy signal	8	2.3%
Put on hold (>5 minutes)	7	2.0%
Disconnected/Not in Service	5	1.4%
Not Answered	3	0.9%
Representative refuses to participate in audit	3	0.9%
Provider practices a different specialty	2	0.6%
Wrong telephone number	2	0.6%
Total	**193**	

[1]Failure totals may include providers that have multiple failures.

[2]Failure rate is based on the total number of providers surveyed (350).

[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Fidelis Care Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with Fidelis Care, their availability to accept new patients, their specialty type, and their telephone number and address. Fidelis Care achieved an overall provider directory accuracy rate of 46.3% in 2025, marking an improvement from the previous year, with the highest compliance rate observed among MLTSS providers.

Table 5: Provider Directory Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	153	162
Accuracy Rate	**43.7%**	**46.3%**

[1] Total number of providers in the sample (no exclusions).
[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	78	39.0%
Pediatric Specialists	50	29	58.0%
Dental	50	24	48.0%
Managed Long-Term Services and Supports	50	31	62.0%
Total	**350**	**162**	**46.3%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not a plan participant	57	16.3%
Provider not at site[3]	38	10.9%
Answering machine/Voice mail system	35	10.0%
Provider not accepting new patients (closed panel)	33	9.4%
Wrong address	19	5.4%
Constant busy signal	8	2.3%
Put on hold (>5 minutes)	7	2.0%
Disconnected/Not in Service	5	1.4%
Not Answered	3	0.9%
Representative refuses to participate in audit	3	0.9%
Provider practices a different specialty	2	0.6%
Wrong telephone number	2	0.6%
Total	**212**	

[1]Failure totals may include providers that have multiple failures.
[2]Failure rate is based on the total number of providers surveyed (350).
[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 206 had their board certification listed in the online provider directory. Among these providers, 60.7% of providers positively confirmed board certification status, representing a decline compared to the 2024 rate. The highest compliance rate in 2025 was observed among MLTSS providers.

Table 8: Provider Directory Board Certification Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Board Certification Listed[1]	219	206
Compliant Providers[2]	146	125
Compliance Rate	**66.7%**	**60.7%**

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	157	94	59.9%
Pediatric Specialists	44	29	65.9%
Dental	2	0	0.0%
Managed Long-Term Services and Supports	3	2	66.7%
Total	**206**	**125**	**60.7%**

[1] Providers who positively confirmed board certification status.

Table 10 and **Table 11** represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 316 had their disability access listed in the online provider directory. Among these providers, 49.4% of providers positively confirmed disability access status, representing a decline compared to the 2024 rate. The highest compliance rate in 2025 was observed among pediatric specialists.

Table 10: Provider Directory Disability Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Disability Access Listed[1]	319	316
Compliant Providers[2]	193	156
Compliance Rate	**60.5%**	**49.4%**

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	178	79	44.4%
Pediatric Specialists	44	33	75.0%
Dental	46	18	39.1%
Managed Long-Term Services and Supports	48	26	54.2%
Total	**316**	**156**	**49.4%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of Fidelis Care's online provider directory to assess how members are informed about a practice site's accessibility features. Fidelis Care's online provider directory does have the ability to filter for specific accessibility features, but the degree of information is limited (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	No
Wheelchair ramps	Yes
General "handicap accessibility" indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- Fidelis Care should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. Fidelis Care should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. This recommendation was also noted in 2024.
- Fidelis Care should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory.
- Fidelis Care should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. This recommendation was also noted in 2024.
- Fidelis Care should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Opportunity for Improvement

- Fidelis Care should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their specific needs, such as those who require accessible examination tables and scales.

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Horizon New Jersey Health

2025 Provider Directory Validation Survey

Survey Period: August 2025 – September 2025

Prepared on behalf of:
The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2025, IPRO's evaluation included the NJ FamilyCare network for Horizon NJ Health (HNJH).

Aim

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' method and scope of reporting practice site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

This report presents the findings of the 2025 Provider Directory Validation Survey for HNJH and includes a comparative analysis of 2024 and 2025 results to assess changes in network adequacy over time.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed HNJH's provider look-up system in August 2025 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.horizonnjhealth.com/findadoctor
Website Access Dates	8/3/25-8/22/25
Survey Date Range	8/12/25-9/11/25

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term service and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and

- accepts new patients enrolled with HNJH.

A random sample totaling 350 providers was prepared for HNJH. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed HNJH's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

HNJH Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, HNJH has an overall provider directory access rate of 41.1% in 2025, representing a decline from the 2024 rate. The highest compliance rates in 2025 were observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	176	144
Access Rate	50.3%	41.1%

[1] Total number of providers in the sample (no exclusions).
[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	82	41.0%
Pediatric Specialists	50	23	46.0%
Dental	50	20	40.0%
Managed Long-Term Services and Supports	50	19	38.0%
Total	350	144	41.1%

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	77	22.0%
Answering machine/Voice mail system	47	13.4%
Provider not a plan participant	34	9.7%
Provider not accepting new patients (closed panel)	25	7.1%
Not Answered	12	3.4%
Disconnected/Not in Service	6	1.7%
Constant busy signal	5	1.4%
Provider practices a different specialty	4	1.1%
Representative refuses to participate in audit	4	1.1%
Put on hold (>5 minutes)	3	0.9%
Wrong telephone number	2	0.6%
Representative does not have enough information to answer the survey questions	1	0.3%
Total	220	

[1]Failure totals may include providers that have multiple failures.
[2] Failure rate is based on the total number of providers surveyed (350).
[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

HNJH Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with HNJH, their availability to accept new patients, their specialty type, and their telephone number and address. In 2025, HNJH had a provider directory accuracy rate of 36.9%, representing a decline from the 2024 rate. The highest compliance rates in 2025 were observed among pediatric specialists and dental providers.

Table 5: Provider Directory Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	161	129
Accuracy Rate	**46.0%**	**36.9%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	70	35.0%
Pediatric Specialists	50	20	40.0%
Dental	50	20	40.0%
Managed Long-Term Services and Supports	50	19	38.0%
Total	**350**	**129**	**36.9%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	77	22.0%
Answering machine/Voice mail system	47	13.4%
Provider not a plan participant	34	9.7%
Provider not accepting new patients (closed panel)	25	7.1%
Wrong address	20	5.7%
Not Answered	12	3.4%
Disconnected/Not in Service	6	1.7%
Constant busy signal	5	1.4%
Provider practices a different specialty	4	1.1%
Representative refuses to participate in audit	4	1.1%
Put on hold (>5 minutes)	3	0.9%
Wrong telephone number	2	0.6%
Representative does not have enough information to answer the survey questions	1	0.3%
Total	**240**	

[1] Failure totals may include providers that have multiple failures.

[2] Failure rate is based on the total number of providers surveyed (350).

[3] Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and Table 9 represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 40 had their board certification listed in the online provider directory. Among these providers, 40.0% of providers positively confirmed board certification status, representing a decline from the 2024 rate. The highest compliance rate in 2025 was observed among primary care providers. There were no board-certified dental or MLTSS providers listed in HNJH's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Board Certification Listed[1]	56	40
Compliant Providers[2]	31	16
Compliance Rate	**55.4%**	**40.0%**

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	32	14	43.8%
Pediatric Specialists	8	2	25.0%
Dental	0	0	N/A
Managed Long-Term Services and Supports	0	0	N/A
Total	**40**	**16**	**40.0%**

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 250 had their disability access listed in the online provider directory. Among these providers, 49.6% of providers positively confirmed disability access status, representing a decline from the 2024 rate. The highest compliance rate in 2025 was observed among primary care providers.

Table 10: Provider Directory Disability Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Disability Access Listed[1]	254	250
Compliant Providers[2]	132	124
Compliance Rate	**52.0%**	**49.6%**

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	177	93	52.5%
Pediatric Specialists	50	24	48.0%

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Dental	11	5	45.5%
MLTSS Services	12	2	16.7%
Total	250	124	49.6%

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of HNJH's online provider directory to assess how members are informed about a practice site's accessibility features. HNJH's online provider directory does have the ability to filter providers with accessibility features, but the degree of information is limited (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	No
Wheelchair ramps	Yes
General "handicap accessibility" indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- As provider directory accuracy rates declined from 2024 to 2025, HNJH should implement routine assessments to verify provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. HNJH should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. This recommendation was also noted in 2024.
- HNJH should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory.

- HNJH should ensure its provider network includes providers offering a range of disability accommodations to meet the diverse needs of members with disabilities. This recommendation was also noted in 2024.
- HNJH should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Opportunity for Improvement

- HNJH should consider including additional accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales. This opportunity for improvement was also noted in 2024.

IPRO

Better healthcare, realized.

UnitedHealthcare Community Plan

2025 Provider Directory Validation Survey

Survey Period: August 2025 – September 2025

Prepared on behalf of:
The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2025, IPRO's evaluation included the NJ FamilyCare network for UnitedHealthcare Community Plan (UHCCP).

Aim

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' method and scope of reporting practice site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

This report presents the findings of the 2025 Provider Directory Validation Survey for UHCCP and includes a comparative analysis of 2024 and 2025 results to assess changes in network adequacy over time.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed UHCCP's provider look-up system in August 2025 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://member.uhc.com/communityplan
Website Access Dates	8/3/25-8/22/25
Survey Date Range	8/18/25-9/16/25

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and

- accepts new patients enrolled with UHCCP.

A random sample totaling 350 providers was prepared for UHCCP. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed UHCCP's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

UHCCP Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, UHCCP achieved an overall provider directory access rate of 61.1% in 2025, marking an improvement from the previous year, with the highest compliance rate observed among dental providers (Table 3).

Table 2: Provider Directory Access Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	197	214
Access Rate	56.3%	61.1%

[1] Total number of providers in the sample (no exclusions).
[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	119	59.5%
Pediatric Specialists	50	33	66.0%
Dental	50	37	74.0%
Managed Long-Term Services and Supports	50	25	50.0%
Total	**350**	**214**	**61.1%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Answering machine/Voice mail system	50	14.3%
Provider not a plan participant	21	6.0%
Provider not accepting new patients (closed panel)	20	5.7%
Provider not at site[3]	14	4.0%
Representative refuses to participate in audit	9	2.6%
Disconnected/Not in Service	7	2.0%
Constant busy signal	6	1.7%
Wrong telephone number	6	1.7%
Provider practices a different specialty	5	1.4%
Put on hold (>5 minutes)	3	0.9%
Total	**141**	

[1]Failure totals may include providers that have multiple failures.
[2]Failure rate is based on the total number of providers surveyed (350).
[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

UHCCP Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with UHCCP, their availability to accept new patients, their specialty type, and their telephone number and address. UHCCP achieved a provider directory accuracy rate of 57.4% in 2025, marking an improvement from the previous year, with the highest compliance rate observed among dental providers.

Table 5: Managed Care Plan Provider Directory Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	178	201
Accuracy Rate	**50.9%**	**57.4%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	112	56.0%
Pediatric Specialists	50	29	58.0%
Dental	50	36	72.0%
Managed Long-Term Services and Supports	50	24	48.0%
Total	**350**	**201**	**57.4%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Answering machine/Voice mail system	50	14.3%
Provider not a plan participant	21	6.0%
Provider not accepting new patients (closed panel)	20	5.7%
Wrong address	17	4.9%
Provider not at site[3]	14	4.0%
Representative refuses to participate in audit	9	2.6%
Disconnected/Not in Service	7	2.0%
Constant busy signal	6	1.7%
Wrong telephone number	6	1.7%
Provider practices a different specialty	5	1.4%
Put on hold (>5 minutes)	3	0.9%
Total	**158**	

[1] Failure totals may include providers that have multiple failures.

[2] Failure rate is based on the total number of providers surveyed (350).

[3] Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 196 had their board certification listed in the online provider directory. Among these providers, 63.3% of providers positively confirmed board certification status in

2025, representing a decline from the 2024 rate. The highest compliance rate in 2025 was observed among primary care providers. There were no board-certified dental or MLTSS providers listed in UHCCP's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Board Certification Listed[1]	194	196
Compliant Providers[2]	131	124
Compliance Rate	**67.5%**	**63.3%**

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	160	104	65.0%
Pediatric Specialists	36	20	55.6%
Dental	0	N/A	N/A
Managed Long-Term Services and Supports	0	N/A	N/A
Total	**196**	**124**	**63.3%**

[1] Providers who positively confirmed board certification status.

Table 10 and **Table 11** represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 320 had their disability access listed in the online provider directory. Among these providers, 61.6% of providers positively confirmed disability access status in 2025, representing a decline from the 2024 rate. The highest compliance rate in 2025 was observed among primary care providers.

Table 10: Provider Directory Disability Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Disability Access Listed[1]	308	320
Compliant Providers[2]	194	197
Compliance Rate	**63.0%**	**61.6%**

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	198	129	65.2%
Pediatric Specialists	49	31	63.3%
Dental	23	13	56.5%
Managed Long-Term Services and Supports	50	24	48.0%

Total	320	197	61.6%

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of UHCCP's online provider directory to assess how members are informed about a practice site's accessibility features. UHCCP's online provider directory has the ability to filter providers with accessibility features, and all provider profiles include a detailed list of available accessibility options. (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	Yes
Accessible scales	Yes
Accessible restrooms	Yes
Bariatric examination tables	Yes
Bariatric scales	Yes
Elevators in multistory buildings	Yes
Handicapped parking	Yes
Lifts	Yes
Signs in braille	Yes
Video access to offsite interpreter	Yes
Wheelchair ramps	Yes
General "handicap accessibility" indicator	No

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- As the provider directory access rates improved from 2024 to 2025, UHCCP should continue with routine assessments verifying provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. UHCCP should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. This recommendation was also noted in 2024.
- As the provider directory board certification rates declined from 2024 to 2025, UHCCP should periodically update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory.
- As the provider directory disability accuracy rates declined from 2024 to 2025, UHCCP should routinely review and update the accessibility options listed in providers' profiles to maintain accuracy. This recommendation was also noted in 2024.

- UHCCP should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Opportunity for Improvement

- UHCCP should include clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility needs.

IPRO

Better healthcare, realized.

Wellpoint New Jersey, Inc.

2025 Provider Directory Validation Survey

Survey Period: August 2025 – September 2025

Prepared on behalf of:
The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2025, IPRO's evaluation included the NJ FamilyCare network for Wellpoint New Jersey, Inc. (WPNJ).

Aim

IPRO's evaluation aimed to:

- validate the accuracy of provider information available to Medicaid members through the MCOs' online provider look-up systems, and
- assess the MCOs' method and scope of reporting practice site accessibility features (e.g., wheelchair access ramps, bariatric scales, etc.) in the online provider look-up systems.

This report presents the findings of the 2025 Provider Directory Validation Survey for WPNJ and includes a comparative analysis of 2024 and 2025 results to assess changes in network adequacy over time.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed WPNJ's provider look-up system in August 2025 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.wellpoint.com/nj/medicaid/search-providers
Website Access Dates	8/3/25-8/22/25
Survey Date Range	8/20/25-9/11/25

Providers eligible for inclusion in the sample met the following criteria:

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and

- accepts new patients enrolled with one of the five Medicaid MCOs.

A random sample totaling 350 providers was prepared for WPNJ. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed WPNJ's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

WPNJ Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, WPNJ has an overall provider directory access rate of 50.9% in 2025, demonstrating an improvement from the 2024 rate. The highest compliance rate in 2025 was observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350
Compliant Providers[2]	153	178
Access Rate	43.7%	50.9%

[1] Total number of providers in the sample (no exclusions).
[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	105	52.5%
Pediatric Specialists	50	33	66.0%
Dental	50	19	38.0%
Managed Long-Term Services and Supports	50	21	42.0%
Total	**350**	**178**	**50.9%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	238	68.0%
Provider not a plan participant	44	12.6%
Answering machine/Voice mail system	39	11.1%
Provider not accepting new patients (closed panel)	20	5.7%
Provider practices a different specialty	8	2.3%
Disconnected/Not in Service	8	2.3%
Wrong telephone number	7	2.0%
Not Answered	5	1.4%
Constant busy signal	3	0.9%
Put on hold (>5 minutes)	3	0.9%
Representative refuses to participate in audit	3	0.9%
Total	**378**	

[1]Failure totals may include providers that have multiple failures.
[2]Failure rate is based on the total number of providers surveyed (350).
[3]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

WPNJ Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with WPNJ, their availability to accept new patients, their specialty type, and their telephone number and address. WPNJ has a provider directory accuracy rate of 46.9%, demonstrating an improvement from the 2024 rate. The highest compliance rate in 2025 was observed among pediatric specialists.

Table 5: Provider Directory Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed[1]	350	350

	Measurement Year	
	2024	2025
Compliant Providers[2]	134	164
Accuracy Rate	**38.3%**	**46.9%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Provider Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	95	47.5%
Pediatric Specialists	50	30	60.0%
Dental	50	18	36.0%
Managed Long-Term Services and Supports	50	21	42.0%
Total	**350**	**164**	**46.9%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate[2]
Provider not at site[3]	238	68.0%
Provider not a plan participant	44	12.6%
Answering machine/Voice mail system	39	11.1%
Wrong address	21	6.0%
Provider not accepting new patients (closed panel)	20	5.7%
Provider practices a different specialty	8	2.3%
Disconnected/Not in Service	8	2.3%
Wrong telephone number	7	2.0%
Not Answered	5	1.4%
Constant busy signal	3	0.9%
Put on hold (>5 minutes)	3	0.9%
Representative refuses to participate in audit	3	0.9%
Total	**399**	

[1] Failure totals may include providers that have multiple failures.

[2] Failure rate is based on the total number of providers surveyed (350).

[3] Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 159 had their board certification listed in the online provider directory. Among these providers, 64.2% of providers positively confirmed board certification status in 2025, demonstrating an improvement from the 2024 rate. The highest compliance rate in 2025 was observed

among primary care providers. There were no board-certified dental providers listed in WPNJ's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Board Certification Listed[1]	116	159
Compliant Providers[2]	69	102
Compliance Rate	**59.5%**	**64.2%**

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	123	80	65.0%
Pediatric Specialists	33	21	63.6%
Dental	0	N/A	N/A
Managed Long-Term Services and Supports	3	1	33.3%
Total	**159**	**102**	**64.2%**

[1] Providers who positively confirmed board certification status.

Table 10 and **Table 11** represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed for MY 2025, 275 had their disability access listed in the online provider directory. Among these providers, 52.7% of providers positively confirmed disability access status in 2025, representing a decline from the 2024 rate. The highest compliance rate in 2025 was observed among pediatric specialists.

Table 10: Provider Directory Disability Accuracy Rate, Measurement Years 2024 to 2025

	Measurement Year	
	2024	2025
Total Providers Surveyed	350	350
Providers With Disability Access Listed[1]	316	275
Compliant Providers[2]	173	145
Compliance Rate	**54.7%**	**52.7%**

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	156	85	54.5%
Pediatric Specialists	41	29	70.7%
Dental	50	17	34.0%
Managed Long-Term Services and Supports	28	14	50.0%

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Total	275	145	52.7%

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of WPNJ's online provider directory to assess how members are informed about a practice site's accessibility features. WPNJ's online provider directory has the ability to filter providers with accessibility features. Additionally, the MCO provides information on a variety of accessibility features. (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	Yes

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	Yes
Accessible scales	Yes
Accessible restrooms	Yes
Bariatric examination tables	Yes
Bariatric scales	Yes
Elevators in multistory buildings	Yes
Handicapped parking	Yes
Lifts	No
Signs in braille	Yes
Video access to offsite interpreter	Yes
Wheelchair ramps	Yes
General "handicap accessibility" indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- As the provider directory accuracy rates improved from 2024 to 2025, WPNJ should continue with routine assessments to validate provider contact information and Medicaid participation status, ensuring improved accuracy and member experience. WPNJ should offer training and resources to provider office staff on the importance of accurate directory information and how to make updates. This recommendation was also noted in 2024.
- As the provider directory board certification rates improved from 2024 to 2025, WPNJ should continue to update and verify board certification status through direct provider engagement and automated checks to reduce errors in the provider directory.

- As the provider directory disability accuracy rates declined from 2024 to 2025, WPNJ should routinely review and update the accessibility options listed in providers' profiles to maintain accuracy.
- WPNJ should implement a feedback tool for members to report inaccuracies or issues with the provider directory information.

Appendix H – Supplemental Documents for all MCOs

Submission Guides for 2025 Annual Assessment Review, and 2025 Care Management Audits (Core Medicaid and MLTSS)

New Jersey Annual Assessment of MCO Operations

Core Medicaid and MLTSS Medicaid
Document Submission Guide
2025

Appendix H1

Access					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
A1		**In 2024, this element (A1) was repositioned under Emergency and Post-Stabilization Services. Contract requirements will be addressed under EPS1.**			
A2*		**In 2024, this element (A2) was repositioned under Emergency and Post- Stabilization Services. Contract requirements will be addressed under EPS2.**			
A3	4.6.3 4.1.1.L. 4.8.7.G 4.1.1.L.3	**4.6.3** **Referral Systems** A. The Contractor shall have a system whereby enrollees needing specialty medical, dental, behavioral health and/or long term services and supports will be referred timely and appropriately. The Contractor shall coordinate the referral process for members with substance use disorders (SUD) with the State's IME. The system shall address authorization for specific services with specific limits or authorization of treatment and management of a case when medically indicated. The Contractor shall maintain and submit a flow chart accurately describing the Contractor's referral system, including the title of the person(s) responsible for approving referrals. The following items shall be contained within the referral system: 1. Procedures for recording and tracking each authorized referral. 2. Documentation and assurance of completion of referrals. 3. Policies and procedures for identifying and rescheduling broken referral appointments with the providers and/or Contractor as appropriate. 4. Policies and procedures for accepting, resolving and responding to verbal and written Member requests for referrals made to the PCP and/or Contractor as appropriate. Such requests shall be logged and documented. Requests that cannot be decided upon	▪ Utilization Management (UM)/Care Management/Pharmacy Referral Policy and Procedures ▪ UM Program Description ▪ Policies and Procedures addressing the following: ▪ Accepting, resolving and responding to verbal and written enrollee requests for referrals made to the PCP and/or Contractor as appropriate ▪ Proper notification of the right to appeal and/or right to request a second opinion when services are denied ▪ Special Needs ▪ Identifying and rescheduling broken referral appointments ▪ Dental Specialty Needs ▪ Long term services and supports ▪ Complex Needs Assessment (CNA) Form ▪ Case Examples ▪ Referral process for MLTSS services; i.e., PDN, TBI therapies, ALR, etc. ▪ Evidence of tracking requests for referrals (including second opinions) to	▪	▪

		immediately shall be responded to in writing no later than five (5) business days from the date of receipt of the request (with a call made to the Member on final disposition) and postmarked the next day. 5. Policies and procedures for proper notification of the Member and where applicable, authorized person, the Member's provider, and the Member's Care Manager, including notice of right to appeal and/or right to request a second opinion when services are denied. 6. A referral form which can be given to the Member or, where applicable, an authorized person to take to a specialist. 7. Referral form mailed, faxed, or sent by electronic means directly to the referral provider. 8. Telephoned authorization for urgent situations or when deemed appropriate by the Member's PCP or the Contractor. 9. Where applicable, the Contractor must also notify the Contractor Care Manager or authorized person. B. The Contractor shall provide a mechanism to assure the facilitation of referrals when traveling by an enrollee (especially when very ill) from one location to another to pick-up and deliver forms can cause undue hardship for the enrollee. Referrals from practitioners or prior authorizations by the Contractor shall be sent/processed within two (2) working days of the request, one (1) day for urgent cases. The Contractor shall have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care. C. The Contractor shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither the Contractor nor its vendor shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor its vendor shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. D. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD.	ensure referral timeliness, dates and methods of member/provider/internal communication, and outcome ▪ Evidence of tracking missed referral appointments and member/provider follow-up ▪ Evidence of standing referrals to specialists in cases of ongoing specialty care ▪ Medical and dental prior authorization procedures and guidelines for decision making ▪ Utilization Management policies and procedures that demonstrate the UM denial process for medical and dental referrals ▪ Member Handbook ▪ Policies and Procedures addressing the following: ▪ Coverage for second opinions ▪ Coverage for out-of-network providers when a participating provider is not available ▪ Single case agreements for covering out-of-network providers		

		E. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for nonemergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee. **4.1.1.L** **Second Opinions** The Contractor shall have a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious medical conditions, for elective surgical procedures, when a physician recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the Contractor's network or the Contractor may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the Contractor's medical and dental procedures and submitted to DMAHS for review and approval. **4.8.7.G** **Out-of-Network Providers** If the Contractor determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the Contractor shall make a referral to an appropriate out-of-network provider, pursuant to a treatment plan approved by the Contractor in consultation with the primary care provider, the non-Contractor participating provider and the enrollee or where applicable, authorized person, at no additional cost to the enrollee. The Contractor shall provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the Contractor may deny a referral. If the Contractor does not have an MLTSS network provider with the appropriate training, experience and availability to meet the particular service needs of the Member, or if the Contractor's			

		network provider cannot meet the timeliness standards set forth by the State, the Contractor shall make a referral to an appropriate out-of-network provider. **4.1.1.I.3** **Out-of-Network Providers** Whenever the Contractor authorizes services by out-of-network providers, the Contractor shall require those out-of-network providers to coordinate with the Contractor with respect to payment. Further, the Contractor shall ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.			

A4*/**	4.5.1.F
	4.8.1.A
	4.8.1.E
	4.8.1.J
	4.2.2.A
	4.2.3.D
	7.8.E
		4.5.1.F
		Dental. While the Contractor must assure that Enrollees with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. The Contractor, therefore, shall accept for network participation dental providers with expertise in the dental management of Enrollees with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. All current providers of dental services to these Members shall be considered for participation in the Contractor's dental provider network. Credentialing and recredentialing standards must be maintained. The Contractor shall make provisions for providers of dental services to these Enrollees to allow for limiting their dental practices at their choice to only those patients with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services.
		
		4.8.1.A
		Provider Network
		The Contractor shall establish, maintain and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access (in accordance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq.) to all services covered under this contract including those with limited English proficiency or physical or mental disabilities.
		
		1. The provider network shall consist of traditional providers for primary and specialty care, including primary care physicians, other approved non-physician primary care providers, physician
			▪ Access and Availability Policy and Procedure (GEO Access Reports)
			▪ Network Development Policy and Procedure
			▪ Provider Recruitment and Retention Committee Charter
			▪ Provider Directory
			▪ Screen print of the Provider Directory on the MCO Website
			▪ Network of dental providers who provide care to special needs enrollees
			▪ Policies and procedures addressing the following:
			  ▪ Family Planning Services
			  ▪ Women's Health Services
			  ▪ Nondiscrimination with respect to provider participation
				▪	▪

		specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers (FQHCs), nursing facilities, residential setting providers for recipients of MLTSS, home and community based services providers and other essential community providers/safety-net providers, and ancillary providers. 2. The provider network shall be reviewed and approved by DMAHS and the sufficiency of the number of participating providers shall be determined by DMAHS in accordance with the standards found in Article 4.8.8 "Provider Network Requirements." 3. In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, the State shall require that, in order to participate as a provider in the Contractor's network that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under NJ FamilyCare and who are enrolled with the Contractor, the provider is enrolled consistent with section 1902(kk) with DMAHS. 4. The Contractor may execute network provider agreements, pending the outcome of section 1902(kk) screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the Provider, and notify affected Members. **4.8.1.E** The Contractor shall include in its network mental health/Substance Use Disorder providers for the Medicaid covered MH/SUD services (as stated in Article 4.1) with expertise to serve enrollees who are clients of the Division of Developmental Disabilities and providers for MH/SUD services (as stated in Article 4.4) for MLTSS Members. **4.8.1.J** The Contractor shall include in its network providers for Managed Long Term Services and Supports. The Contractor's network shall include all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0).			

		4.2.2.A **Family Planning Services and Supplies** Except where specified in Section 4.1, the Contractor's MCO enrollees are permitted to obtain family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The Contractor shall reimburse family planning services provided by non-participating Network providers based on the Medicaid fee schedule. All Providers must be registered with New Jersey Medicaid as 21st Century Cures Act Providers in order to provide services to NJ FamilyCare members. **4.2.3** **.D** **Women's Health Services** The Contractor shall provide female enrollees with direct access to a woman's health specialist within its network for covered care necessary to provide women's routine and preventive health care services. This shall be in addition to the enrollee's designated PCP if that PCP is not a women's health specialist. **7.8.E** **Nondiscrimination Requirements** The Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.			
A4a* – Core Medicaid	4.8.3 4.8.3.D 4.11	**4.8.3** **Provider Network File Requirements**	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS	▪	▪

PCPs - Adults	4.11.A	The Contractor shall provide a certified provider network file quarterly, to be reported electronically in a format and software application system determined by DMAHS that will include <u>every</u> provider including MLTSS, Behavioral Health (BH), and dental providers in the Contractor's network. The Contractor shall demonstrate its compliance with provider network requirements and how it will assure enrollee access to all benefits covered under this contract. **4.8.3.D** The quarterly provider file shall include a unique identifying number for each individual provider. The National Provider Identifier (NPI) for covered entities and the professional license number are required. Non Traditional Providers shall be identified with the provider's EIN, tax number, license number, UPIN, Medicaid provider number, Medicare provider number, and Social Security Number where applicable. **4.11** **Expanded Readiness Review (ERR) Submission Requirements** The Contractor shall submit any significant or material changes regarding changes to the health care delivery systems or changes to Contractor operations including vendor and subcontractors relationships to DMAHS for final approval. Changes to health care delivery systems or Contractor operations shall include, but not be limited to: a. Benefit administration b. New subcontractor agreements and/or changes in subcontractor, per article 4.9.1 c. Changes in administration of assessments or care management, including delegation d. Claims processing and payment e. Enrollee access to benefits f. Incentive payment programs **4.11.A** **Requirements for ERR Submission**	▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely ▪ GeoAccess Reports for all Counties ▪ NAR GeoAccess Summary Reports ▪ Waiver(s) granted from DMAHS		

		The submission must be sent at least 90 days prior to being published, distributed, and/or implemented. The Contractor may propose effective dates for the changes to be implemented, but the changes may not be implemented until DMAHS reviews and approves the proposed change. Submissions must follow DMAHS guidance. Implementation without DMAHS approval may result in corrective actions taken by DMAHS			
A4b* – Core Medicaid PCPs – Pediatric		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely	▪	▪
A4c* – Core Medicaid Specialty Providers		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely	▪	▪
A4d* – Core Medicaid Dental/ Specialty Dental		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely	▪	▪
A4e* - Core Medicaid Hospitals		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely	▪	▪

A4f** – MLTSS Providers		See A4a - Contract Requirement Language	▪ Provider Report/Grid of MLTSS Network ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely	▪	▪
A5	4.8.1.L **4.5.3.A**	**4.8.1.L** **Enrollees with Special Needs** The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs. 1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home. 2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs. **4.5.3.A** **CLIENTS OF THE DIVISION OF DEVELOPMENTAL DISABILITIES** The Contractor shall provide all physical health services required by this contract as well as the MH/SUD services included in the Medicaid State Plan to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. The Contractor shall include in its provider network a specialized network of providers who will deliver both physical as well as MH/SUD services, in accordance with Medicaid program standards to adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SUD services to clients of DDD until the behavioral health ASO is implemented.	▪ Policies and Procedures addressing the following: ➢ Access and Availability ➢ Credentialing /Recredentialing ➢ Specialized Network for DDD members ▪ Provider Manual ▪ Provider application (with special needs check list and age group physician treatments) ▪ Provider Contract ▪ Provider Directory ▪ Special Needs Survey	▪	▪

A6	4.8.4	**4.8.4** **Provider Directory Requirements** A. As cited by HHS in the ONC 21st Century Cures Act final rule (also published of the Federal Register) at 45 CFR170.215, Effective beginning January 1, 2021 (with enforcement date of July 1, 2021), Provider Directory Application Programming Interface (API) must be accessible via a public-facing digital endpoint on the payer's website to ensure public discovery and access. At a minimum, Contractors must make available via the Provider Directory API provider names, addresses, phone numbers, and specialties. All directory information must be made available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of Contractor receiving provider directory information or an update to the provider directory information. B. The Contractor shall maintain a web-based/on-line provider directory. DMAHS staff and HBC staff will access the web-based/on-line directory as needed to assist members. The web-based provider directories shall be maintained with updates made no later than every seven (7) days. • Primary care providers along with any associated physician assistants, and dentists/PCDs who will serve enrollees listed by County, by city, by specialty • Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); website URLs as appropriate, telephone number; fax number if available; office hours at each location; whether the provider is accepting new enrollees, indicates whether a provider serves enrollees under the age of six, indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP or PCD. • This shall include a separate listing of dental providers who: ➢ Provide dental services to members under the age of six (6). ➢ Provide dental services to members with intellectual and developmental disabilities. Separate lists shall be available for providers treating children and adult members.	▪ Provider Directory	▪	▪

		➢ All of these listings shall be updated as needed and at a minimum quarterly. • Contracted specialists along with any associated physician assistants, and ancillary services providers who will serve enrollees Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C. • MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), website URLs as appropriate, telephone number and fax number if available and information on service area and services offered and whether the provider is accepting new enrollees. • Behavioral Health Providers should be listed in on-line directory by the service description below: o Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization o Adult Mental Health Rehabilitation (AMHR) o Inpatient Psychiatric Hospital Care o Independent Practitioner(s) (Neuropsychologist; Psychiatry; NP Psychiatric MH; Neurology (Osteopaths Only); Psychologist) o Medication Monitoring o Outpatient Mental Health Hospital o Outpatient Mental Health Independent Clinic o Partial Care • Behavioral Health Providers (Autism services) should be listed in on-line directory by the service description below: o Autism Treatment Services - ABA (Independent Practitioner) o Autism Treatment Services - ABA (Group Practice) o Autism Treatment Services - DIR (Independent Practitioner) o Autism Treatment Services - DIR (Group Practice) • Behavioral Health Providers (SUD - Substance Use Disorder) should be listed in the on-line directory by the service description below: o Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 – WM			

		07/2024 Subsequent Amendment Accepted Article 4 – Page 126 ○ Non-Medical Detoxification / Non-Hospital based withdrawal management ASAM 3.7 – WM ○ Substance Use Disorder Short Term Residential (STR) ASAM 3.7 ○ Substance Use Disorder Long Term Residential (LTR) ASAM 3.5 ○ Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM ○ Substance Use Disorder Partial Care (PC) ASAM 2.5 ○ Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1 ○ Substance Use Disorder Outpatient (OP) ASAM 1 ○ Opioid Treatment Services ASAM OTP (Methadone Maintenance) ○ Opioid Treatment Services (Non-Methadone Maintenance) ○ Medication Assisted Treatment in Physician Office (w/ Navigator) ○ Medication Assisted Treatment in Physician Office (w/o Navigator) The web-based/on-line directory shall include the ability for members to filter for the above behavioral health providers by a 5, 10, 15, 20, and 25-mile radius. C. Subcontractors • Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.			
A7*	4.7.2.A.3 4.7.2.A.10 5.12 B.4.14.X.I B.4.14.XI Appendices	**4.7.2.A.3** **Appointment Availability Studies** The Contractor shall conduct a review of appointment availability and submit a report to DMAHS annually. The report must list the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review. **4.7.2.A.10**	• Evidence of submitting annual appointment availability report to DMAHS ▪ Copy of DMAHS responses to appointment availability report ▪ Provider Manual ▪ Provider Directory ▪ Member Handbook ▪ Member Newsletter	•	•

		Annual PCP After-Hour Availability Study The Contractor shall conduct an annual PCP After-Hour Availability study in order to monitor availability and accessibility to primary care providers (PCPs). The study shall be designed to determine a provider's availability for telephone consultation after regular business hours. The Contractor shall survey, at a minimum, no less than 25% of its PCP network. The PCPs are to be randomly selected from the Contractor's provider network file. Providers shall be contacted after business hours or on weekends. Providers and staff should be asked to identify the system the office uses for telephone coverage after regular business hours. A telephone response should be considered acceptable/unacceptable based on the following criteria: Acceptable – An active provider response, such as: 1. Telephone is answered by PCP, office staff, answering service or voice mail. 2. The answering service either: • Connects the caller directly to the provider; • Contacts the PCP on behalf of the caller and the provider returns the call; or • Provides a telephone number where the PCP/covering provider can be reached. 3. The provider's answering machine message provides a telephone number to contact the PCP/covering provider. Unacceptable: 1. The answering service: • Leaves a message for the provider on the PCP/covering provider's answering machine; or • Responds in an unprofessional manner. 2. The provider's answering machine message: • Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling	▪ Policies and Procedures addressing the following: ➢ Access and Appointment Availability Standards ➢ Appointment Scheduling Assistance ➢ PCP Appointment Availability ➢ Verification of Appointment Availability ▪ PCP Appointment Availability Audit tool, results and follow-up with non-compliant providers ▪ PCP After Hours Availability Audit tool, results and follow-up with non-compliant providers ▪ Call Center Performance Measures ▪ Call Center Monthly or Quarterly Performance Reports ▪ Telecommunications Device for the Deaf Contract		

		the caller to speak with the provider for non-emergent situations. • Instructs the caller to leave a message for the provider. 3. No answer; 4. Listed number no longer in service; 5. Provider no longer participating in the Contractor's network; 6. On hold for longer than five (5) minutes; 7. Answering Service refuses to provide information for survey; 8. Telephone lines persistently busy despite multiple attempts to contact the provider. The Contractor shall submit a report of the results of the survey and its corrective action plan to the DMAHS annually. The report shall also include the methodology and sample size used for the survey. **5.12** **Appointment Availability** The Contractor shall have policies and procedures to ensure appointments for medical, mental health/substance use disorder (for DDD clients and MLTSS Members) and dental care are available in accordance with the following standards at no less than a 90% benchmark and are reported in a format approved by the State: A. Emergency Services. Immediately upon presentation at a service delivery site. B. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening. C. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention. D. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits. E. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care			

		Provider (PCP). Emergency appointments must be provided within 24 hours of referral. F. Urgent Specialty Care. Within twenty-four (24) hours of referral. G. Baseline Physicals for New Adult Enrollees. Within one hundred-eighty (180) calendar days of initial enrollment. H. Baseline Physicals for New Children Enrollees and Adult Clients of DDD. Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. I. Prenatal Care. Enrollees shall be seen within the following timeframes: 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester J. Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar. K. Lab and Radiology Services. Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care. L. Waiting Time in Office. Less than forty-five (45) minutes. M. Initial Pediatric Appointments. Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees. N. For dental appointments, the Contractor shall be able to provide: 1. Emergency dental care, which is the immediate care, treatment and/or referral for emergent dental conditions, and defined previously as serious orofacial conditions which require immediate medical intervention, to avoid placing the health of the individual in jeopardy. 2. Urgent dental care, which is defined as oral and/or dental conditions which require timely treatment to alleviate pain, address infection risk and avoid additional degradation of the teeth and/or other oral structures, within twenty-four (24) hours of member request. 3. Routine non-symptomatic care and/or specialist referrals within twenty-eight (28) days of member request. O. For MH/SUD appointments, the Contractor shall provide: 1. Emergency services immediately upon presentation at a service delivery site. 2. Urgent care appointments within twenty-four (24) hours of the request.			

		3. Routine care appointments within ten (10) days of the request. P. Maximum Number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children. Q. For SSI and New Jersey Care – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment. **B.4.14.X.I** The MCO takes steps to promote accessibility of all services offered to Members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include: 1. The points of access to primary care, behavioral health, specialty care, inpatient services and MLTSS are identified for Members. 2. At a minimum, Members are given information about: a. how to obtain services during regular hours of operations; b. how to obtain emergency and after-hours care; c. how to obtain second opinions; d. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care; e. how to select a PCP from among those accepting new enrollees; and. f. physical accessibility. **B.4.14.XI** The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and Member service lines and MLTSS contact lines). Performance on these dimensions of access are assessed against the standards.			
A8*	**4.7.4.A**	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested	▪ Narratives and supporting documentation should be filed within each review element as appropriate ▪ Documentation should reflect the review period.	▪	▪

		in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance		
Emergency and Post-Stabilization Services					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
EPS1	4.2.1.B 4.2.1.H.4	**4.2.1.B** **Emergency Services** The Contractor shall be responsible for emergency services, both within and outside the Contractor's enrollment area, as required by an enrollee in the case of an emergency. Emergency services shall also include: 1. Medical examination at an Emergency Room which is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours. 2. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect. 3. Post-Stabilization of Care. The Contractor shall comply with 42 CFR 438.114(e) and 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor's network if: a. The services were pre-approved by the Contractor or its providers; or b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care; or c. The Contractor could not be contacted for	• Policies and Procedures addressing the following: ➢ Emergency Care/Post-Stabilization ➢ Access and Availability, and Primary Care Provider (PCP) After Hours Availability ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print	•	•

		pre-approval. The Contractor's financial responsibility for post-stabilization care services, if not pre-approved, ends when: i. A physician in the Contractor's network with privileges at the treating hospital assumes responsibility for the Member's care. ii. A physician in the Contractor's network assumes responsibility for the Member's care through transfer. iii. Contractor and the treating physician reach an agreement concerning the Member's care. iv. The Member is discharged. **4.2.1.H.4** **Emergency Services** The Contractor shall be liable for payment for the following emergency services provided to an enrollee: 4.The enrollee's PCP or other Contractor representative instructs the enrollee to seek emergency care in-network or out-of-network, whether or not the patient meets the prudent layperson definition.			
EPS2*	4.6.2.L	**4.6.2.L** **Emergency Care** The Contractor shall have methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.	▪ Policies and Procedures addressing the following for the Core Medicaid population and the MLTSS population ➢ Over/Under Utilization ▪ Over/Under Utilization Reports ▪ Provider Profiling Programs ▪ Provider Profiles ▪ ER Utilization Report ▪ ER Utilization Programs ▪ ER Initiatives Including Outcomes ▪ MLTSS Critical Incident Reports	▪	▪
EPS3	4.2.1.l	**4.2.1.I** **Emergency Services – Lists of Diagnoses or Symptoms** The Contractor may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.	▪ Policies and Procedures addressing the following: ➢ Emergency Care ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print	▪	▪

EPS4	4.2.1.K.2	**4.2.1.K.2** **Emergency Services - Notification** The Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Contractor or the enrollee's PCP of the enrollee's screening and treatment.	• Policies and Procedures addressing the following: ➢ Emergency Care ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print	•	•
EPS5	4.2.1.H.2	**4.2.1.H.2** **Emergency Services – Stabilization** All emergency services are medically necessary until the clinical emergency is stabilized. This includes all treatment that is necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility. If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, or transfer the patient.	• Policies and Procedures addressing the following: ➢ Post-Stabilization ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print	•	•
EPS6*	**4.7.4.A**	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate ▪ Documentation should reflect the review period ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance	▪	▪

Quality Assessment and Performance Improvement					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
Q1*	4.6.1.A	**4.6.1.A** **Quality Assessment and Performance Improvement Plan** The Contractor shall implement and maintain a Quality Assessment and Performance Improvement (QAPI) program that is capable of producing prospective, concurrent, and retrospective analyses. Delegation of any QAPI activities shall not relieve the Contractor of its obligations to perform all QAPI functions.	▪ Quality Management/Quality Assurance Program Description ▪ QI Work Plan - Previous year and current ▪ Quality Management Program Evaluation for the previous year ▪ Entire Year of the most recent Meeting Minutes – QI, Provider Advisory, etc. ▪ Various committee meeting minutes (e.g., QI, Provider Advisory, etc.) that may demonstrate oversight.	▪	▪
Q2*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall carry out the activities described in its QAPI. The Contractor shall develop and submit to DMAHS and/or the EQRO at the direction of the State, an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including MLTSS-related quality activities.	▪ QI/Annual Work Plan – previous year and current ▪ Documentation demonstrating implementation and evaluation of the plan ▪ Documentation demonstrating the inclusion and implementation evaluation **of MLTSS related activities in QAPI.**	▪	▪
Q3*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall also prepare and submit to DMAHS and/or the EQRO at the direction of the State, an annual report on quality assurance activities which demonstrate the Contractor's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.	▪ QI Program Evaluation for previous year ▪ Annual Quality Reports	▪	▪

Q4*	B.4.14.II.A-G Appendix	**B.4.14.II.A-G** The Quality Assessment and Performance Improvement program has written guidelines for its quality of care studies and related activities which include: A) specification of clinical or health services delivery areas to be monitored; B) use of quality indicators; C) use of clinical care standards/practice guidelines; D) analysis of clinical care and related services; E) implementation of remedial/corrective actions; F) assessment of effectiveness of corrective actions; and G) evaluation of continuing and effectiveness of the QAPI.	▪ QI Program Description - Current ▪ QI Work Plan - Previous year and current ▪ Clinical Studies and Projects Policy and Procedure ▪ Desk top procedures	▪	▪
Q5*	B.4.14.II Appendix	**B.4.14.II** The Quality Assessment and Performance Improvement program objectively and systematically monitors and evaluates the quality and appropriateness of care and service, including MLTSS, to enrollees, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.	▪ QI Program Description ▪ QI Work Plan	▪	▪
Q6*	B.4.14.VI Appendix	**B.4.14.VI** The Quality Assessment and Performance Improvement program has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.	▪ Current QI Program Description ▪ Quality Management Organizational Chart ▪ Departmental job descriptions or bios	▪	▪
Q7*	B.4.14.VII.A B.4.14.VII.E Appendices	**B.4.14.VII.A** Participating physicians and other providers are kept informed about the written QA plan. **B.4.14.VII.E** Description of how providers are to be involved in the design, implementation, review and follow-up of quality activities.	▪ QI Program Description ▪ Provider Manual ▪ Provider Newsletters ▪ Screen Prints of the MCO's – Provider Website ▪ PAC Charter ▪ Entire Year of the most recent Provider Advisory Committee (PAC) Meeting Minutes, Agendas, and Attendance Sheets	▪	▪
Q8*	B.4.14.XV.A Appendix	**B.4.14.XV.A** **Scope** The MCO shall document that it is monitoring the quality of care across all services, including MLTSS, and all treatment modalities, according to its written QAPI . (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agenda, Attendance Sheets ▪ QI Program Evaluation for previous year ▪ Member Quality of Care Compliant Analysis ▪ Quarterly and Annual Quality of Care Reports MLTSS related reports	▪	▪
Q9*	B.4.14.XVI Appendix	**B.4.14.XVI**	▪ QI Program Description	▪	▪

		The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels. A. QA information is used in recredentialing, recontracting and/or annual performance evaluations. B. QA activities are coordinated with other performance monitoring activities, including utilization management, Care Management, risk management, and resolution and monitoring of Member grievances. C. There is a linkage between QA and the other management functions of the health plan such as: 1. network changes; 2. benefits redesign; 3. medical management systems (e.g., pre-certification); 4. practice feedback to physicians; 5. patient education; 6. Member services, and; 7. Care Management including MLTSS Care Management.	▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ QI Program Evaluation for previous year		
Q10*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪

Quality Management					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
Sub-heading	4.6	**4.6** A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicaid and NJ FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports.			

		B. The Contractor shall use its best efforts to ensure that persons and entities providing care and services for the Contractor, including long-term services and supports, in the capacity of physician, dentist, CNP/CNS, physician's assistant, CNM, or other medical service professional meet applicable licensing, certification, or qualification requirements under New Jersey law or applicable state laws in the state where service is provided, and that the functions and responsibilities of such persons and entities in providing medical, behavioral, dental and/or MLTSS care and services under this contract do not exceed those permissible under New Jersey law. This shall also include knowledge, training and experience in providing care and services to individuals with special needs as well as services provided by non-traditional MLTSS service providers.			
QM1	4.6.2.A	**4.6.2.A** **Guidelines** The Contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.	▪ Provider Manual ▪ Documentation showing how providers are notified of guideline updates including MLTSS. ▪ Provider/Member Newsletter ▪ Screen Prints of MCO Provider Website with list of Clinical Practice Guidelines ▪ Policies and Procedures addressing the following: ➢ Clinical Practice Guidelines ▪ Individual Practice Guidelines ▪ MLTSS Guidelines	▪	▪
QM2	4.6.2.B	**4.6.2.B** **Treatment Protocols** The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning and contributing family and social factors.	▪ Care Management /UM Workflow Diagrams ▪ QI or UM Program Descriptions ▪ Redacted cases showing adjustments based on the enrollee's medical condition and/or contributing family and social factors ▪ Policies and Procedures addressing the following: ➢ Treatment Protocol Adjustment	▪	▪
QM3*	4.6.2.C	**4.6.2.C** **Monitoring** The Contractor shall have procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.	▪ Clinical Practice Guidelines ▪ HEDIS® and CAHPS® Results and Analysis ▪ Provider Profiles ▪ Utilization Reports specific to individual providers ▪ UM Program Description ▪ QI Program Description	▪	▪

			▪ QI Work Plan ▪ Provider Profiling Program ▪ Provider files to demonstrate corrective action taken to bring practitioner into compliance with clinical practice guidelines or average utilization of services		
QM4*	4.6.2.D	**4.6.2.D** **Focused Evaluations** The Contractor shall have procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied. The Contractor shall also have procedures for conducting problem-oriented clinical studies of individual care.	▪ QI Program ▪ QI Program Evaluation ▪ Quality of care case examples and tracking ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Policies and Procedures addressing the following: ➢ Quality of Care ➢ Over/Under Utilization ➢ Emergency Room Utilization ➢ Monitoring of Mortality Rates ▪ Credentialing - Covers the monitoring of quality of care concerns during the recredentialing process ▪ Provider Monitoring Reports	▪	▪
QM5*	4.6.2.E	**4.6.2.E** **Follow-up** The Contractor shall have procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution shall follow the standard described in Article 5.15.1B.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service ▪ Grievance Database Report/Logs ▪ Example of a Grievance Acknowledgement Letter ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Blinded Case Example of Quality of Care Concern	▪	▪
QM6	4.6.2.F	**4.6.2.F** **Hospital Acquired Conditions and Provider–Preventable Conditions** The Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR 434, 438, and 447. Policies and procedures	▪ Policies and Procedures addressing the following: ➢ Hospital Acquired Conditions ➢ Claims Payment ▪ Quality Outcomes Reports ▪ Denial Letters	▪	▪

		shall be submitted to the DMAHS for review and approval prior to implementation of the Contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes. The Contractor shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. The Contractor shall identify Other Provider-Preventable Conditions for non-payment as wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html	▪ Educational Materials		
QM7	4.6.2.G	**4.6.2.G** **Data Collection** The Contractor shall have procedures for gathering and trending data including outcome data.	▪ Policies and Procedures addressing the following: ➢ Data Collection Methods ➢ Analysis of Outcome Data ▪ Work Plans ▪ QI Program Description ▪ QI Program Evaluation ▪ Monitoring Reports ▪ ER utilization Reports ▪ Enrollee & Provider Grievances Policy and Procedure	▪	▪
QM8*	4.6.2.H	**4.6.2.H** **Mortality Rates** The Contractor shall review inpatient hospital mortality rates of its enrollees.	▪ Policies and Procedures addressing the following: ➢ Quality of Care ▪ Monthly Mortality Reports ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Flowcharts, Algorithm ▪ QI Program Description ▪ QI Work Plan ▪ QI Program Evaluation ▪ Mortality Initiatives Including Outcomes	▪	▪
QM9*	4.6.2.I	**4.6.2.I** **Corrective Action**	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service and/or Flowchart	▪	▪

		In compliance with 42 CFR 438.230(b)(4), the Contractor shall have procedures for informing subcontractors and providers of identified deficiencies, or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes. The Contractor shall conduct reassessments to determine if corrective action yields intended results.	➢ Credentialing/Recredentialing ➢ Corrective Action Plan procedure if separate from Quality of Care Policy and Procedure ▪ Request for a Corrective Action Plan (CAP) Letter to provider ▪ CAP Reminder Letters ▪ CAP Approval Letter; Closure Letter to provider ▪ Entire Year of the most recent Oversight Committee Meeting Minutes ▪ Confirmed Quality of Care Case Example		
QM10	4.6.2.M	**4.6.2.M** **New Medical Technology** The Contractor shall have policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and durable medical equipment (DME).	▪ Policies and Procedures addressing the following: ➢ Technology Assessment ➢ Decisions Policy ▪ Evidence-based literature from peer-reviewed journals ▪ Provider Manual ▪ Provider Newsletters ▪ Entire Year of the most recent Oversight/New Technology Committee Meeting Minutes	▪	▪
QM11a*	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	▪ Core Medicaid PIP Submission Worksheets or Other PIP Documentations ▪ Core Medicaid Special Initiatives Including Outcomes	▪	▪
QM11b**	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with	▪ MLTSS PIP Submission Worksheets or Other PIP Documentations ▪ MLTSS Special Initiatives Including Outcomes	▪	▪

		input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."			
QM12*	4.7.2.D	**4.7.2.D** The Contractor shall conduct reviews/audits which focus on the special dental needs of enrollees with developmental disabilities. Using encounter data reflecting the utilization of dental services and other data sources, the Contractor shall measure clinical outcomes; have these outcomes evaluated by clinical experts; identify quality management tools to be applied; and recommend changes in clinical practices intended to improve the quality of dental care to enrollees with developmental disabilities.	▪ Encounter Data Reports/Other Data Reports ▪ Audit Procedure ▪ Most recent Audit Results ▪ Dental Initiatives for enrollees with Developmental Disabilities including outcomes	▪	▪
QM13*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪
QM14	4.2.6.B.1.d	**4.2.6.B.1.d** Section 1905(r) of the Social Security Act (42 U.S.C. § 1396(d) and federal regulation 42 C.F.R. § 441.50 et seq. requires EPSDT services to include: 1. d. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by the Contractor. The following list of screening tests is not all inclusive: ▪ Hemoglobin/hematocrit/EP ▪ Urinalysis	▪ QI Evaluation ▪ Data Reports	▪	▪

		▪ Tuberculin test – intradermal, administered annually and when medically indicated ▪ Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child: - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age - at 18-26 months, preferably at twenty-four (24) months of age - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested ▪ Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.			
QM15	4.2.6.B.10.a,b	**4.2.6.B.10.a,b** **Lead Screening** The Contractor shall provide a screening program for the presence of lead toxicity in children which shall consist of two components: verbal risk assessment and blood lead testing. a. Verbal Risk Assessment – The provider shall perform a verbal risk assessment for lead toxicity at every periodic visit to children at least six (6) months and less than seventy two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions: i. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint? ii. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint? iii. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling? iv. Have any of your children or their playmates had lead poisoning? v. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community. vi. Do you give your child home or folk remedies that may contain lead?	▪ QI Program Description ▪ QI Evaluation ▪ Policy and Procedures	▪	▪

		Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answer to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child must be tested according to age groups specified in 4.2.6.B.8.b. A child's risk category can change with each administration of the verbal risk assessment. b. Blood Lead Testing – All screening must be done through a blood lead level determination. The Contractor must implement a screening program to identify and treat high-risk children for lead-exposure and toxicity. The screening program shall include blood level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. A confirmatory blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, and once between 18-26 months, preferably at twenty-four (24) months If a child between the ages of twenty four (24) months and seventy two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the			

		time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages than stated in 4.2.6.B.1.d. i. If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed according to the schedule in 4.2.6.B.8. ii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing. iii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, the contractor should recommend a follow-up venous blood screening for the child, and blood lead testing for the other children and pregnant women living in the household. iv. When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, the contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation. v. When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, the Contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding the child's care, including the scheduling and results of follow-up blood lead tests. vi. When laboratory results are received, the Contractor shall require PCPs to report to the Contractor all children with blood lead levels > 5 µg/dl. Conversely, when a provider other than the PCP has reported the			

		lead screening test to the Contractor, the Contractor shall ensure that this information is transmitted to the PCP.			
QM16	4.2.6.B.10.c	**4.2.6.B.10.c** c. On a semi-annual basis, the Contractor shall outreach, via letters and informational materials to parents/custodial caregivers of all children enrolled in the Contractor's plan who have not been screened, educating them as to the need for a lead screen and informing them how to obtain lead screening and transportation to the screening location.	▪ QI Program Description ▪ Policy and Procedures ▪ Outreach Reports ▪ Member Letters ▪ Member Educational Materials	▪	▪
QM17	4.2.6.B.10.d	**4.2.6.B.10.d** d. On an annual basis, the Contractor shall send letters to PCPs who have lead screening rates of less than 80% for two consecutive six-month periods, educating them on the need and their responsibility to provide lead screening services. The eligible population of children shall be identified using methodology as defined by the State.	▪ QI Program Description ▪ QI Program Evaluation ▪ Policy and Procedures ▪ Reports ▪ Provider Letters ▪ Provider Educational Materials	▪	▪
QM18*	4.6.2.P	**4.6.2.P** **PERFORMANCE MEASURES** The Contractor shall submit to DMAHS and/or the EQRO at the direction of the State, annually, on a date specified by the State, performance measures in accordance with the following: 1. HEDIS and NJ Specific Performance Measures. a. HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the Contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS). b. HEDIS reporting requirements shall be consistent with National Committee for Quality Assurance (NCQA) requirements found in the current HEDIS Technical Specifications. Measure rotation is not permitted. c. Electronic Submission requirements include: • HEDIS ROADMAP; • Complete HEDIS Workbook; • Interactive Data Submission System (IDSS) results; • Final Audit Report; • Source Code;	▪ TPL Allocation Table ▪ Member Level Files ▪ HEDIS Roadmap ▪ Locked IDSS ▪ CSV Data File ▪ ART ▪ Final Audit Report ▪ NJ Specific Measures ▪ Source Code as needed For Core Set Measure(s): ▪ Member Level Files ▪ Source Code as needed ▪ Rate Tables ▪ Workplans and/or CAPs as needed	▪	▪

		• New Jersey Performance Measures results; • Member level data for select HEDIS and New Jersey Specific measures, at the discretion of the State, per EQRO file layout and submission instructions; and • A table that delineates how the populations are defined and included or excluded from performance measures following yearly guidance provided by the State and/or EQRO. d. Contractors must comply with all audit standards and requirements determined by NCQA. e. Contractors must comply with Medicaid reporting requirements, including but not limited to beneficiary category assignments as defined by the State. f. HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook. g. New Jersey Performance Measures o Age Appropriate Blood Lead Testing in Children (Multiple Lead Testing in Children through 26 months of age) h. Following yearly guidance provided by the State and/or EQRO, Contractors shall submit a Workplan by each August 15th, or other time period as requested by the DMAHS. At the State's discretion, a CAP may be required. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where services are potentially below quality standards. These performance standards will reflect the minimum acceptable service level. The performance standards may be revised as necessary to ensure that they are reasonable and accurately reflect quality expectations. The Contractor shall provide updates as requested by the State to confirm the progress of the interventions proposed to the DMAHS. 2. Core Set Measure(s) a. Following yearly guidance provided by the State and/or EQRO, the Contractor shall submit specified Core Set Measures. Yearly guidance will be based upon CMS requirements, including but not limited to measure-eligible populations and stratification. Electronic submission requires member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions. b. At the State's discretion, a Workplan and/or CAP may be requested of the MCOs if the performance does not reflect the minimal acceptable service level.		

QM19**	9.11.F	**9.11.F** **MLTSS Performance Measures** The Contractor shall comply with all quality metric reporting requirements, including but not limited to: a. Contractor shall utilize the State's electronic templates for Performance Measures (PMs). b. Contractor shall comply with the EQRO PM validation process. c. Contractor shall comply with the State's requirements for timeliness, accuracy, and quality of report submissions. d. Monthly reporting of MLTSS Operational Metrics tracking and quarterly reporting of claims and provider statistics per reporting templates specified by the DMAHS.	▪ Process description for production of each MLTSS performance measure ▪ Source Code (as required) ▪ Data sources used in producing the measures ▪ Preliminary rates (sample file) for all measures ▪ Member/Event-level detail files NOTE: If the above documents have been submitted for all MLTSS PMs during the review period, do not submit again. ▪ Report of all submissions (monthly, quarterly and annual) of MLTSS measures during the review period showing date due to State, date initially submitted to IPRO, and date initially submitted to State.	▪	▪
QM20*	4.2.6.A.6 4.2.6.A.6.a 4.2.6.A.6.b 4.2.6.B.3.a.i 4.2.6.B.3.a.ii	**4.2.6.A.6** The contractor shall provide all PCDs on a quarterly basis a list of the PCD's enrollees who have not complied with the NJFC requirement (4.2.6.B) for dental services beginning by the age of 12 months or who have not had a subsequent dental visit for oral evaluation or preventive service bi-annually. The PCD shall be required to contact these Enrollees to schedule an appointment. Documentation by the PCD of outreach efforts and responses in the patient's record is required. **4.2.6.A.6.a** When members are assigned a PCD, the list will be generated based on assignment. **4.2.6.A.6.b** When members are not assigned a PCD, the list will be generated for the dentist based on member's previous 12 months claim history. **4.2.6.B.3.a.i** A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is recommended. **4.2.6.B.3.a.ii**	▪ Provider training on Dental EPSDT requirements ▪ Evidence of tracking Dental EPSDT services ▪ Monitoring Reports on PCP Dental referrals based on EPSDT requirements ▪ Referrals during PCP visits for dental follow-up ▪ Provider Site Visit Audit Tool showing evidence of NJ Dental EPSDT requirements ▪ Most recent Medical Record Review audit findings	▪	▪

		Follow up at well child visits through the age of twenty (20) to determine that dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided.			
Efforts to Reduce Healthcare Disparities					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
D1*	4.6.2.T.1 4.6.2.T.2	The contractor shall develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following: **4.6.2.T.1** Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including but not limited to: race, ethnicity, language, disability status, age, sex, sexual orientation, gender identity, geography, and/or other variables; **4.6.2.T.2** Barrier analysis and a written action plan to address the disparities identified;	▪ Reports and Analysis conducted by the plan to identify disparities ▪ Action Plan to address disparities identified ▪ Policies and Procedures related to the identification of disparities	▪	▪
D2*	4.6.2.T.3	**4.6.2.T.3** Implementation of an action plan with continuous monitoring of outcomes; and	▪ Disparities in the healthcare workplan ▪ Documentation demonstrating incorporation of disparities in healthcare into plan activities	▪	▪
D3*	4.6.2.T.4	**4.6.2.T.4** Ongoing evaluation of the effectiveness of the action plan	▪ Policies and Procedures relating to the identification and monitoring of disparities in healthcare ▪ Disparities in the healthcare workplan ▪ Reports and Analysis conducted by the plan to re-evaluate disparities in healthcare	▪	▪
D4*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪

D5*/**	**4.6.2.Q.5**	**4.6.2.Q.5** **Performance Improvement Project Categories.** PIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years. PIPs are to be implemented for NJ FamilyCare/Medicaid Members. At least one PIP must include activities that advance health equity, through the identification and reduction of health care disparities. which may include addressing health-related social needs.	▪ MCOs PIP submissions should clearly identify and reduce healthcare disparities.	▪	▪
Committee Structure					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
CS1*	4.2.9	**4.2.9** **HEALTH PROMOTION AND EDUCATION PROGRAMS** The Contractor shall identify relevant community issues (such as disease outbreaks, violence, social determinants of health, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and, issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups, including results from community engagement and input from the Community/Health Education Advisory Committee (CHEAC), the MLTSS Community Advisory Committee, and the Provider Advisory Committee. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. Health promotion and education activities shall, whenever possible, reduce one or more health disparities. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health	▪ Community Needs Assessment from State and local governmental agencies ▪ QI Program Description ▪ QI Work Plan ▪ List/Schedule of Community Outreach Activities for the previous year and planned for the upcoming year ▪ Tracking Log of Completed Activities ▪ Community Needs Assessment from State and local governmental agencies ▪ HEDIS® and CAHPS® Results and Analysis ▪ Entire year of the most recent meeting minutes showing discussion of activities	▪	▪

		promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include: 1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs. 2. Guidelines for Member referral. 3. Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and Contractor's guidelines for assessment and referral. 4. Embedding information about evidence-based programs in provider and Member training initiatives. 5. A tracking mechanism for referral and program completion. 6. Designation of a liaison to DHS for evidence-based disease prevention. Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. In accordance with P.L. 1968, c. 413, as amended by P.L. 2017, c. 161. Diabetes services to include but are not limited to: 1. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or Certified Nutrition Specialist (CNS) for members diagnosed with diabetes, gestational diabetes or pre-diabetes. MNT shall be consistent with evidence-based practice guidelines published by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association) . 2. Diabetes Self-Management Education (DSME) to be provided by a Certified Diabetes Educator for members diagnosed with diabetes or gestational diabetes. The DSME program shall meet current quality standards established by either The American Association of			

		Diabetes Educators (AADE) or The American Diabetes Association (ADA). 3. The National Diabetes Prevention Programs (NDPPs), for members diagnosed with prediabetes, which meets the standards of The National Diabetes Prevention Program established by the Center for Disease Control and Prevention (CDC). E. Signs and symptoms of common diseases and complications F. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness G. Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish). H. Prevention and treatment of alcohol and Substance Use Disorder I. Coping with losses resulting from disability or aging J. Self-care training, including self-examination K. Need for clear understanding of how to take over-the-counter and prescribed medications and the importance of coordinating all such medications L. Understanding the difference between emergent, urgent and routine health conditions M. Information and education on good oral hygiene practices and habits, and the need for regular dental visits and completion of treatment as prescribed by a dentist. N. Strategies to reduce the risk of unintentional injuries			
CS2*	4.6.1.C.1 4.6.1.C.2 4.7.2.A.8 B.4.14.IV A-E B.4.14.V Appendices	**4.6.1.C.1** **QM Committee** The Contractor shall have adequate general liability insurance for Members of the QM committee and subcommittees, if any. The committee shall include representation by providers who serve enrollees with special needs and those eligible for MLTSS. **4.6.1.C.2** **Medical Director(s)** The Contractor shall have at least one on-site Medical Director(s) currently licensed in New Jersey as a Doctor of Medicine or Doctor of Osteopathic Medicine. The Contractor shall determine the requisite number of additional Medical Director(s) necessary to ensure the delivery of integrated medical, behavioral, and dental and MLTSS services.	▪ QI Program Description ▪ QI Work Plan ▪ Quality Management/QI Committee Charter ▪ Entire Year of the most recent QI Committee Meeting Minutes, Membership List and Attendance Sheets ▪ Organizational Chart ▪ Medical Director Job Description ▪ Copy of medical director's valid and current medical license ▪ Provider Advisory Committee (PAC)/Medical Advisory Committee (MAC) membership lists ▪ Entire Year of the most recent PAC/MAC Charter, Meeting Minutes and Attendance Sheets	▪	▪

		The Contractor shall ensure that Medical Director(s) have training and experience including but not limited to, serving populations: • With chronic health care conditions • With co-occurring medical and behavioral health disorders • With physical and or intellectual disabilities • Who meet or are at risk to meet nursing facility level of care The Medical Director(s) shall be responsible for: a. The development, interpretation and implementation of medical, behavioral and dental health policies and procedures to guide and support the provision of medical, behavioral and dental care to enrollees; b. The development, interpretation and implementation of MLTSS policies and procedures to guide and support the provision of MLTSS to enrollees; c. Oversight of physical, behavioral and MLTSS provider recruitment activities; d. Reviewing all providers' applications and making recommendations to those with contracting authority regarding credentialing and reappointing all providers prior to the providers' contracting (or renewal of contract) with the Contractor's plan; e. Continuing surveillance of the performance of providers in their provision of health care to enrollees; f. Administration of all clinical activities of the Contractor; g. Continuous assessment and improvement of the quality of care and services provided to enrollees; h. Serving as Chairperson of Quality Management Committee; [Note: the medical director may designate another physician to serve as chairperson with prior approval from DMAHS.] i. Oversight of all provider education, in-service training and orientation; j. Assuring that adequate staff and resources are available for the provision of medical, behavioral and MLTSS services to enrollees;	▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Forms showing attestations regarding ability to treat enrollees with special needs		

		k. Coordinating with other Medical Directors, as necessary, to ensure integrated and coordinated medical, behavioral, dental and MLTSS services (formal and informal) for MLTSS Members; and l. The review and approval of studies and responses to DMAHS concerning QM matters. **4.7.2.A.8** The Contractor shall submit on an annual basis to DMAHS and/or the EQRO at the direction of the State, documentation of its ongoing internal quality assurance activities. Such documentation shall include at a minimum: a. Agenda of quality assurance meetings of its medical and service professionals; and b. Attendance sheets with attendee signatures. c. Minutes of all Quality Assurance meetings, approved and signed. **B.4.14.IV** **ACTIVE QA COMMITTEE** - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO, including those QA functions regarding MLTSS. This committee or other structure has: **A. regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly. **B. established parameters for operating** - The role, structure and function of the structure/committee are specified. **C. documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions. **D. accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions. **E. membership** - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers, including MLTSS providers whose function is to support the enrollee's ability to receive services in the setting of their choice.		

		B.4.14.V **QAPI SUPERVISION** - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.			
CS3	4.6.2.BB	**4.6.2.BB** **Provider Advisory Committee (PAC)** The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long term care needs and special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes, including but not limited to the Contractor's Cultural and Linguistic Competency Plan and related activities. On an annual basis, the Contractor shall report to DMAHS and/or its EQRO on the membership of this committee, participation of its members, and the committee's activities which demonstrate compliance with related Contract requirements.	▪ QI Program Description ▪ QI/PAC Charter ▪ Entire Year of the most recent PAC Meeting Minutes, Agendas, membership Lists and Attendance Sheets ▪ Reports showing the percentage of Medicaid enrollees served by providers on the committee ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Provider Directory ▪ Provider Database File ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agendas, and Sign-In Sheets	▪	▪
CS4	4.6.2.BB.1	**4.6.2.BB.1** The Contractor shall have a Dental Affairs Advisory Subcommittee to give participating dental providers the opportunity to provide input to the MCO in improving dental performance rates based on CMS-416 data and quality of care.	▪ Dental Affairs Advisory Subcommittee Charter ▪ Entire Year of the most recent Dental Affairs Advisory Subcommittee Meeting Minutes, Agendas, and Attendance Sheets ▪ Dental Affairs Advisory Subcommittee Membership List ▪ Entire Year of the most recent PAC Meeting Minutes ▪ Entire Year of the most recent QI Meeting Minutes ▪ Dental initiatives including outcomes	▪	▪
CS5	4.6.1.C.9	**4.6.1.C.9** **Dental Director** The Contractor shall have on staff a full time (minimum 40 hours per week) Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery or a Doctor of Dental Medicine. The Dental Director must have practiced in New Jersey and shall be responsible for:	▪ Dental Service Coordinator Job Description ▪ Organizational Chart ▪ Entire Year of the most recent Dental Advisory Meeting Minutes, Agenda, and Attendance Sheets	▪	▪

		a. The development, implementation and interpretation of clinical criteria and dental policies and procedures in accordance with DMHAS and NJFC regulations (N.J.A.C> 10:56, DMHAS Newsletters and the NJ FamilyCare Dental Clinical Criteria Policy) to guide and support the provision of dental care by both the Contractor and its subcontractor (if applicable) to include Provider notification of changes within 30 days. b. Oversight or shared oversight of dental provider recruitment, credentialing and recredentialing activities with emphasis placed on the recruitment and retention of providers who treat members with special needs and/or disabilities; c. Monitoring of the dental network, including review of all dental applications, to ensure network adequacy standards are met, including but not limited to provider ratios, in-county minimum, office hour minimums, and geographical accessibility standards, as set for in the Contract; d. Surveillance of the performance of providers (including the providers of their subcontractor), in their provision of dental care to enrollees. This includes but is not limited to; identifying and addressing quality of care, continuity of care (to include orthodontic treatment and other multi-visit procedures), member outreach for missing EPSDT dental periodicity services and fraud, waste and abuse; e. Administration and oversight of all dental activities of the Contractor and review all written information and materials provided to the public, Members and Providers for contract compliance; f. Where applicable, monitors IDD, SHCN and pediatric member assignment for appropriateness; g. Continuous assessment and improvement of utilization of dental services and the quality of dental care provided to Members. This shall apply to the EPSDT requirement for the first year dental visit, establishing a dental home by the age of two (2), increased utilization for pediatric preventive dental services by PCDs and oral health services by non-dental providers/medical personnel for members through age five (5);			

		h. Serving on the Contractor's Quality Management Committee; serving on the Contractor's credentialing committee and/or the subcontractor's credentialing committee when applicable; i. Oversight of the orientation, education, and in-service training provided to network providers to include collection of attestations for fluoride varnish application by medical personnel; j. Reviewing dental consultants for inter-rater reliability and monitor consultants' activities quarterly for compliance; k. Assuring that adequate Contractor staff and resources are available for prompt response to member and provider concerns, State referrals, requests for various deliverables and the appeals process; l. The review and approval of studies, reports and responses to DMAHS concerning utilization and Quality matters; m. Representing the Contractor at Medicaid Fair Hearings and IUROs; n. Representing the Contractor at meetings of the Dental Advisory Council of DMAHS; o. If the Contractor contracts with a dental subcontractor, the Contractor's Dental Director shall provide direction and monitor its performance to ensure contract compliance and continuous quality improvement; ensure that decisions are made in a clinically-appropriate and timely manner based on the current clinical criteria policy; review all written information and materials provided to the public, Members and Providers to ensure the subcontractor complies with NJ FamilyCare policies, New Jersey State Board of Dentistry regulations, and that the Contractor's name is prominently displayed on all subcontractor materials; p. Verification on a monthly basis that dental providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs.			
CS6	4.6.2.Z	**4.6.2.Z** **Community/Health Education Advisory Committee** ▪ The Contractor shall implement and maintain community linkages through the formation of a Community/Health Education	▪ Community/Health Education Advisory Committee (HEAC) Charter ▪ Committee Membership List including titles	▪	▪

		Advisory Committee (CHEAC) with demonstrated participation of consumers, and providers. The Contractor's CHEAC shall consist of: 1. Members being served by the Contractor (or their authorized persons, including members representative of the population served when considering race, ethnicity, language, NJ FamilyCare eligibility categories, disability status, age, sex, sexual orientation, gender identity, geography, use of behavioral health services, and use of MLTSS, 2. Individuals and providers with knowledge of and experience with serving elderly people, people with disabilities or people eligible for MLTSS, including a representative from the MLTSS CAC; and 3. Representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The Contractor may invite other Member/Authorized Persons and Provider participation in CHEAC on an ad hoc or ongoing basis, such as traditional and safety net providers and representatives from the Provider Advisory Committee. The CHEAC shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The Contractor shall ensure that the CHEAC responsibilities include advisement on educational and operational issues affecting groups who speak a primary language other than English and cultural competency. The Contractor shall include and involve the CHEAC in reviewing results and developing and updating the Contractor's Cultural and Linguistic Competency Plan as well as policy and procedures related to QAPI, consumer surveys and health education. The CHEAC should consider Contractor performance with respect to Health Equity, CLAS, and SDOH and must be allowed to make related recommendations and the Contractor must record and evaluate implementation of such recommendations to the Contractor. The Contractor must provide resources to support required CHEAC activities. On an annual basis, the Contractor shall report to DMAHS and/or its EQRO on the membership of this committee, as well as the committee's activities and must document, as requested, compliance with related Contract requirements.	▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the Community/Health Education Advisory Committee activities ▪ QI Program Description		

CS7	B.4.14.X.H	**B.4.14.X.H** **enrollee/Member suggestions -** Opportunity is provided for Members to offer suggestions for changes in policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ HEAC Charter ▪ Entire Year of the most recent HEAC Meeting Minutes, Attendance List, Agendas ▪ Entire Year of the most recent Committee Meeting Minutes as appropriate ▪ Member Handbook	▪	▪
CS8***	4.6.2.AA	**4.6.2.AA** **MLTSS Consumer Advisory Committee**. The Contractor shall establish an MLTSS Consumer Advisory Committee (CAC) including representation of MLTSS stakeholders, a representative group of MLTSS population participants, or individuals representing those enrollees, case managers, and others, and will address a broad range of topics related to MLTSS including consideration of how those topics interact with issues related to health equity, SDOH, and CLAS. Not less than once per year, the MLTSS CAC must review the Contractor's Cultural and Linguistic Competency Plan and related activities. The MLTSS CAC must be allowed to make related recommendations to the Contractor. The Contractor must provide resources to support required MLTSS CAC activities. On an annual basis, the Contractor shall report to DMAHS and/or its EQRO on the membership of this MLTSS CAC, participation of its members, and the committee's activities which demonstrate compliance with related Contract requirements.	▪ MLTSS CAC Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the MLTSS CAC activities ▪ QI Program Description	▪	▪
CS9*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪
Programs for the Elderly and Disabled					

2025 Element	Contract Reference	Contract Requirement Language	Documentation Examples	Met/Not Met	Review Comments
Sub-heading	4.6.2.R 4.6.2.R.1 4.6.2.R.1.g	**4.6.2.R** **Care for Persons with Disabilities and the Elderly** (Defined as SSI-Aged and New Jersey Care – Aged enrollees and SSI and New Jersey Care enrollees with disabilities). The Contractor shall have the system capability to track and report on each population separately. **4.6.2.R.1** The Contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for NJ FamilyCare elderly enrollees and enrollees with disabilities, and MLTSS Members. **4.6.2.R.1.g** The Contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit (See Article 4.7).			
ED1	4.6.2.R.1.a	**4.6.2.R.1.a** Oversee quality of life indicators, such as: i. Degree of personal autonomy; ii. Provision of services and supports that assist people in exercising medical and social choices; iii. Self-direction of care to the greatest extent appropriate; iv. Maximum use of natural support networks; and v. Maintenance of optimal level of functioning.	▪ QI Work Plan ▪ Adult and Pediatric Complex Needs Assessment (CNA) ▪ New Jersey Choice Assessment ▪ Health Risk Assessment (HRA) ▪ Quality Improvement Program Description ▪ Care Management Program Description ▪ Care of Persons with Disabilities and the Elderly Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Care Management examples for the specific population	▪	▪
ED2	4.6.2.R.1.b	**4.6.2.R.1.b** Review persistent or significant grievances from elderly enrollees, enrollees with disabilities, and MLTSS Members or their authorized person, identified through Contractors' grievance procedures and through external oversight;	▪ Policies and procedures addressing the following: ▪ Grievances ▪ Special Needs Enrollee Grievance Summary by category and analysis of findings ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Enrollee Appeals Summary and Analysis	▪	▪

ED3	4.6.2.R.1.c	**4.6.2.R.1.c** Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Policies and Procedures addressing the following: ➢ Care Management of the Elderly and the Disabled ➢ Review and Revision of Policies and Procedures ▪ Quality of Care/Service Policy and Procedure ▪ QI Program Description ▪ Clinical Practice Guidelines	▪	▪
ED4	4.6.2.R.1.d	**4.6.2.R.1.d** Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Disabled and Elderly quarterly, semiannual or annual grievance summary and analysis ▪ Over/Under Utilization of Services Report ▪ Quality of Care/Services Reports ▪ Drug Utilization Review Report and Analysis ▪ Quality Outcomes Report and Analysis ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes	▪	▪
Sub-heading	4.6.2.R.1.e	**4.6.2.R.1.e** **Care for Persons with Disabilities and the Elderly** Develop written procedures and protocols for at least the following:			
ED5	4.6.2.R.1.e.i	**4.6.2.R.1.e.i** Assessing the quality of complex health care/Care Management;	▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Adult CNA Form ▪ HRA ▪ Initiatives Developed to Address Deficiencies including Outcomes	▪	▪
ED6	4.6.2.R.1.e.ii	**4.6.2.R.1.e.ii** Ensuring Contractor compliance with the Americans with Disabilities Act (ADA); and	▪ Policies and Procedures addressing the following: ➢ Americans with Disabilities Act Policy ➢ Credentialing/Recredentialing	▪	▪

			▪ Provider Manual ▪ Provider Participating Agreement ▪ Provider Office Site Audit Tool ▪ Provider Application ▪ Corrective Action Plans for non-compliant providers ▪ Examples of provider site visit summaries ▪ Initiatives Developed to Address Deficiencies including Outcomes		
ED7	4.6.2.R.1.e.iii	**4.6.2.R.1.e.iii** Instituting effective health and function management protocols for elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the ▪ following: ➢ Care of Persons with DDD and the Elderly and the institution of effective health management protocols ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Health Risk Assessment ▪ Adult CNA Form ▪ New Jersey Choice Assessment ▪ MLTSS Level of Supervision Assessment (CRS-settings) ▪ Treatment Protocols (e.g., Milliman & Robertson® or InterQual®) ▪ Preventive Health Guidelines	▪	▪
ED8	4.6.2.R.1.f	**4.6.2.R.1.f** Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the following: ➢ Care of Persons with DDD and the Elderly ▪ Quality Outcomes Report and Analysis ▪ QI Program Description ▪ Provider Manual ▪ QI Program Evaluation ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes	▪	▪
Sub-heading	4.6.2.R.2	**4.6.2.R.2** **Initiatives for Aged, including MLTSS Members**			

		The Contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:			
ED9	4.6.2.R.2.a	**4.6.2.R.2.a** The Contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:	▪ Pneumococcal Vaccination and Influenza Immunizations Program Description ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ State Program Approval ▪ Provider Manual ▪ Provider Newsletters ▪ Pneumococcal Vaccination and Influenza Immunization Initiatives	▪	▪
ED10	4.6.2.R.2.a.i	**4.6.2.R.2.a.i** Development, distribution, and measurement of PCP compliance with practice guidelines;	▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Provider Specific HEDIS® Results ▪ Provider Profiling Program ▪ Provider Profiling Reports ▪ Physician Practice Overview Reports ▪ Follow-up on non-compliant providers ▪ Screen Prints	▪	▪
ED11	4.6.2.R.2.a.ii	**4.6.2.R.2.a.ii** Educational outreach for enrollees and practitioners;	▪ Pneumococcal vaccination and Influenza Immunizations Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives developed to address deficiencies including outcomes	▪	▪
ED12	4.6.2.R.2.a.iii 4.6.2.R.2.a.iv	**4.6.2.R.2.a.iii** Access for ambulatory and homebound enrollees; **4.6.2.R.2.a.iv**	▪ Policies and Procedures addressing the following: ➢ Access to pneumococcal vaccines and influenza immunizations for homebound enrollees	▪	▪

		Mechanism to report to DMAHS, via encounter data, all immunizations given.	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Member Handbook ▪ Screen Prints of the Enrollee Website ▪ Health Risk Assessment ▪ 3 Blinded Care Management Records		
ED13	4.6.2.R.2.b	**4.6.2.R.2.b** The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, breast and prostate cancer screening. The Program shall include the following components:	▪ Preventive Cancer Screening Program Description ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ HEDIS® Results and Analysis ▪ Enrollee Preventive Health Screenings Reports including barrier analysis, initiatives developed to address deficiencies and outcomes ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ Provider Manual ▪ Provider Newsletters	▪	▪
ED14	4.6.2.R.2.b.i	**4.6.2.R.2.b.i** Measurement of provider compliance with performance standards;	▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints	▪	▪
ED15	4.6.2.R.2.b.ii	**4.6.2.R.2.b.ii** Education outreach for both enrollees and practitioners regarding preventive cancer screening services;	▪ Preventive Cancer Screening Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters	▪	▪

			▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives Developed to Address Deficiencies including Outcomes		
ED16	4.6.2.R.2.b.iii	**4.6.2.R.2.b.iii** Breast cancer screening in accordance with Centers for Disease Control (CDC) recommendations;	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual	▪	▪
ED17	4.6.2.R.2.b.iv	**4.6.2.R.2.b.iv** Prostate cancer screening in accordance with CDC recommendations.	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual	▪	▪
ED18	4.6.2.R.2.b.v	**4.6.2.R.2.b.v** Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.	▪ Provider Manual ▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Records Audit ▪ Medical Record Review Program ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider medical review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes	▪	▪
ED19	4.6.2.R.2.c	**4.6.2.R.2.c** The Contractor shall develop specific programs for the care of enrollees identified with congestive heart failure, chronic obstructive lung disease (COPD), diabetes, hypertension, and depression. The program shall include the following:	▪ Disease Management Program Descriptions for the following: ➢ Congestive heart failure (CHF) ➢ Chronic obstructive pulmonary disease (COPD) ➢ Diabetes ➢ Hypertension (HTN) ➢ Depression	▪	▪

			▪ Care Management Program Description ▪ Community Based Care Management Description ▪ CHF, COPD, Diabetes, HTN and Depression Initiatives Including Outcomes ▪ Educational Materials		
ED20	4.6.2.R.2.c.i	**4.6.2.R.2.c.i** Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ 3 Blinded Examples of Enrollee Care Plans ▪ Screen Prints	▪	▪
ED21	4.6.2.R.2.c.ii	**4.6.2.R.2.c.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Disease Management/Complex Case Management Annual Outcomes Report for the Specified Populations ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Profiling Program Description ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports	▪	▪
ED22	4.6.2.R.2.c.iii	**4.6.2.R.2.c.iii** Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;	▪ Examples of educational materials for enrollee and caregivers ▪ Disease Management Programs for specified disease states ▪ Educational Program Evaluations	▪	▪
ED23	4.6.2.R.2.c.iv	**4.6.2.R.2.c.iv** Educational materials for clinical providers in the best practices of managing the disease; and	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials	▪	▪
ED24	4.6.2.R.2.c.v	**4.6.2.R.2.c.v** Evaluation of effectiveness of each program by measuring outcomes of care.	▪ Disease Management Program ▪ Disease Specific Outcomes Report ▪ HEDIS® Results and Analysis	▪	▪

			▪ Annual Disease Management Program Evaluation ▪ QI Evaluation ▪ Outcomes Report ▪ Disease Specific Program Evaluations		
ED25	4.6.2.R.2.d	**4.6.2.R.2.d** The Contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:	▪ Policies and Procedures addressing the following: ➢ Care of Persons with cognitive impairments and the elderly ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Annual Outcomes Report ▪ Annual Outcomes Analysis ▪ HRA	▪	▪
ED26	4.6.2.R.2.d.i	**4.6.2.R.2.d.i** Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description Care Management of enrollees with cognitive impairments ▪ 3 Blinded Examples of Enrollee Care Plans	▪	▪
ED27	4.6.2.R.2.d.ii	**4.6.2.R.2.d.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Outcome Reports ▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ QI Work Plan ▪ QI Evaluation ▪ Disease Management/Complex Care Management Annual Outcomes Report for the Specified Population ▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports	▪	▪

			▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports		
ED28	4.6.2.R.2.d.iii	**4.6.2.R.2.d.iii** Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and	▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Examples of Educational Material for Enrollee and Caregivers ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Case Examples	▪	▪
ED29	4.6.2.R.2.d.iv	**4.6.2.R.2.d.iv** Educational materials for clinical providers in the best practices of managing cognitive impairments.	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials	▪	▪
ED30*	4.6.2.R.2.e	**4.6.2.R.2.e** **Initiatives to Prevent Long-Term Institutionalization (LTI)** Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions. This program shall include, but is not limited to, the following:	▪ LTI Program Description ▪ LTI Initiatives Including Outcomes		
ED31*	4.6.2.R.2.e.i	**4.6.2.R.2.e.i** Identification of medical and social conditions that indicate risk of being institutionalized;	▪ Desk Top Procedures ▪ CNA ▪ Utilization Management Process Flowcharts ▪ Risk Assessments ▪ Redacted cases of Identification of At-risk Enrollees	▪	▪
ED32*	4.6.2.R.2.e.ii	**4.6.2.R.2.e.ii** Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management Program Description ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Utilization Management cases ▪ Examples of Care Plans	▪	▪

			▪ Provider Communications ▪ Desk-Top Procedures ▪ Utilization Management/Case Management Notes ▪ Provider Programs addressing the prevention of LTI		
ED33*	4.6.2.R.2.e.iii	**4.6.2.R.2.e.iii** Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Protocols addressing preventive services for at-risk enrollees ▪ CNA ▪ HRA ▪ UM Cases ▪ Blinded Enrollee Care Plans ▪ Prevention of LTI Desk-Top Procedures	▪	▪
ED34*	4.6.2.R.2.e.iv	**4.6.2.R.2.e.iv** Provision of home/community services covered by the Contractor.	▪ Policies and Procedures addressing the following: ➢ Home Care and Private Duty Nursing ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Referral Desk-Top Procedure ▪ CNA ▪ Blinded Enrollee Care Plan ▪ Blinded Case File	▪	▪
ED35	4.6.2.R.2.f	**4.6.2.R.2.f** Abuse and Neglect Identification Initiative: Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Care Management ▪ Risk Assessments ▪ CNA ▪ Employee Training ▪ Blinded Case Example showing suspected abuse and neglect ▪ Care Management Program Description	▪	▪

			▪ Community Based Care Management Description ▪ MLTSS Member training on Abuse/Neglect identification and reporting.		
ED36	4.6.2.R.2.f.i	**4.6.2.R.2.f.i** Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Diagnostic tools for identifying enrollee abuse and neglect ▪ Customer Service Script ▪ Customer Service Education related to potential abuse and neglect ▪ Data Triggers	▪	▪
ED37	4.6.2.R.2.f.ii	**4.6.2.R.2.f.ii** Protocols and interventions to treat abuse and neglect of enrollees, including ongoing evaluation of the effectiveness of these protocols and interventions; and	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Abuse and Neglect Protocols ▪ Case Management file of an enrollee that has had confirmed abuse and neglect ▪ Descriptions of interventions for treating abuse and neglect ▪ Program Evaluation ▪ Care Management Program Description ▪ Community Based Care Management Description	▪	▪
ED38	4.6.2.R.2.f.iii 4.6.2.R.2.f.iv	**4.6.2.R.2.f.iii** Coordination of these efforts through the PCP. **4.6.2.R.2.f.iv** Reporting of MLTSS-related critical incidents in accordance with Article 9.	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ Case example of confirmed abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Educational Materials	▪	▪

			▪ CI reporting procedures and reports		
Sub-heading	4.6.2.S	**4.6.2.S** For the elderly, enrollees with disabilities, and MLTSS Members, the Contractor shall monitor, evaluate and report on Member outcomes at least annually. The Contractor shall have the system capability to track and report on each population separately, and make available the results of the evaluation to DMAHS and/or the EQRO during the annual assessment audits (See Article 4.7). The Contractor shall include of the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and Care Management, and other activities as indicated:			
ED39*	4.6.2.S.1	**4.6.2.S.1** Aspiration pneumonia	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Aspiration pneumonia Initiatives Including Outcomes	▪	▪
ED40*	4.6.2.S.2	**4.6.2.S.2** Injuries, fractures, and contusions	▪ Outcome Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Injuries, fractures, and contusions Initiatives Including Outcomes	▪	▪
ED41*	4.6.2.S.3	**4.6.2.S.3** Decubiti	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Decubiti Initiatives Including Outcomes	▪	▪

ED42*	4.6.2.S.4	**4.6.2.S.4** Seizure management	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Seizure Management Initiatives Including Outcomes	▪	▪
ED43**	9.7.5	**9.7.5** **Nursing Facility Diversion** A. The Contractor shall develop and implement a nursing facility diversion process that shall be approved by the State and CMS prior to implementation. The nursing facility diversion plan shall include, but not be limited to the following provisions: 1. Comprehensive clinical assessment process that identifies Members' health care and service needs; 2. Options Counseling process that ensures Members are educated on the full range of LTSS and offered a choice of care (institutional/home and community based services) and option to choose MLTSS or PACE (if available); and 3. A person-centered Plan of Care (POC) approach is implemented; 4. Monitoring hospitalizations, short term NF stays and identifying issues and strategies to improve diversion outcomes, and B. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary. The Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified below: 1. MLTSS members who request admission to a nursing facility for custodial care; 2. MLTSS members residing in the community who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services; 3. MLTSS members that the Contractor becomes aware are admitted to an inpatient hospital and who are not residents of a nursing facility.	▪ State approved Nursing Facility Diversion program which includes: ▪ Identification of members for inclusion in the program ▪ Clinical assessment process ▪ Education to members regarding the process	▪	▪
ED44*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS**	▪ Narratives and supporting documentation should be filed within each review element as appropriate.	▪	▪

		A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		
Provider Training and Performance					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
PT1	3.7.1.A.1 4.6.2.V 4.6.4.A.3 7.24.D 7.24.E	**3.7.1.A.1** The system shall provide reports to monitor and identify deviations of patterns of treatment from established standards or norms and established baselines. These reports shall profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals. **4.6.2.V** **Provider Performance Measures** The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. Data shall be supplied to providers for their management activities. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate: 1. Resource utilization of services, specialty and ancillary services; 2. Clinical performance measures on outcomes of care; 3. Maintenance and preventive services; 4. Enrollee experience and perceptions of service delivery; and 5. Access. **4.6.4.A.3**	▪ Policies and Procedures addressing the following: ➢ Provider Profiling including panel size requirements ▪ Provider Profiling Program Description ▪ Most recent Provider Profile Results ▪ Cover letter for Provider Profiling ▪ Utilization of Special Services Report (MRI, CT SCAN, etc.) ▪ Various data including ER, Drug and Dental Services Utilization ▪ HEDIS® Results and Analysis ▪ EPSDT Monitoring ▪ Outcomes Reports ▪ CAHPS® Reports ▪ Member Grievance Analysis Reports ▪ Access Reports ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)	▪	▪

		Data Collection and Reporting The plan shall provide for systematic utilization data collection and analysis, including profiling of provider utilization patterns and patient results. The Contractor must use aggregate data to establish utilization patterns, allow for trend analysis, and develop statistical profiles of both individual providers and all network providers. Such data shall be regularly reported to the Contractor management and Contractor providers. The plan shall also provide for interpretation of the data to providers. **7.24.D** The Contractor shall provide its primary care practitioners with quarterly utilization data within forty-five (45) days of the end of the program quarter comparing the average medical care utilization data of their enrollees to the average medical care utilization data of other managed care enrollees. These data shall include, but not be limited to, utilization information on enrollee encounters with PCPs, children who have not received an EPSDT examination or a blood lead screening, specialty claims, prescriptions, inpatient stays, and emergency room use. **7.24.E** The Contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians and other health care practitioners participate. The Contractor shall review and assess data using statistically valid sampling techniques including, but not limited to, the following: Primary care practitioner audits; specialty audits; inpatient mortality audits; quality of care and provider performance assessments; quality assurance referrals; credentialing and recredentialing; verification of encounter reporting rates; quality assurance committee and subcommittee meeting agendas and minutes; enrollee grievances, appeals, and follow-up actions; providers identified for trending and sanctioning, including providers with low blood lead screening rates; special quality assurance studies or projects; prospective, concurrent, and retrospective utilization reviews of inpatient hospital stays; and denials of off-formulary drug requests.			
PT2	4.6.1.C.4	**4.6.1.C.4**	▪ Policies and Procedures addressing the following:	▪	▪

		Medical Record standards shall address Medical, Behavioral, Dental, and MLTSS records. Records shall also contain notation of any cultural/linguistic needs of the enrollee.	➢ Medical Record Documentation Standards ➢ Dental Record Documentation Standards ➢ Medical Records Audit ▪ Provider Manual ▪ Medical and Dental Record Review Programs ▪ Medical and Dental Record Review Audit Tools ▪ Most recent Medical and Dental Record Review Audit Findings ▪ Provider medical/dental review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes		
PT3	4.6.2.K	**4.6.2.K** **Ethical Issues** The Contractor shall comply and monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including, but not limited to: ▪ Advance Directives, ▪ Family Planning services for minors, and ▪ Other issues as identified. The Contractor shall submit a report within thirty (30) days to DMAHS with changes or updates to the policies.	▪ Policies and Procedures addressing the following: ➢ Medical Records Documentation Standards ➢ Treatment of Minors ➢ Medical Records Audit ➢ Advance Directives ➢ Medical Records Standards ▪ Most recent Medical Records Audit findings ▪ Provider Manual ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes	▪	▪
PT4	4.6.2.N	**4.6.2.N** **Informed Consent** The Contractor is required and shall require all participating providers to comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers. Copies of the forms are included in Section B.4.15 of the Appendices.	▪ Policies and Procedures addressing the following: ➢ Informed Consent ➢ Informed Consent for hysterectomies and sterilizations ▪ Examples of Consent Forms with instructions ▪ Provider Manual ▪ Monitoring Procedures	▪	▪

			▪ Claims Denial Logs ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)		
PT5*	4.7.2.E	**4.7.2.E** The Contractor shall produce reports of all PCPs in its network (regardless of panel size), who are treating children under 21 years old, that provide information to the PCPs of underutilization or no utilization of their enrollee panel Members as compared to Early Periodic Screening and Diagnostic Testing (EPSDT) utilization requirements.	▪ Provider Profiling Program ▪ Provider Profiling Procedures ▪ Provider Profiles ▪ EPSDT Monitoring ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)	▪	▪
PT6	6.3.A	**6.3.A** **Provider Education and Training** A **Initial Training**. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants. Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups.	▪ Policies and Procedures addressing the following: ➢ Provider Education ▪ Provider Training Overview/Program ▪ Provider Toolkit/Training Curriculum ▪ Signed Acknowledgement of Training Forms ▪ Training Attendance Forms or Learning Management System (LMS) attendance reports ▪ Provider Manual ▪ Dental Services Provider Manual ▪ Medical and Dental Provider Welcome Letters ▪ PowerPoint Presentations ▪ Tracking Logs for provider trainings	▪	▪
PT7	6.3.B	**6.3.B** **Ongoing Training** The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms	▪	▪

			▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers		
PT8*	B.4.14.XII.A Appendix	**B.4.14.XII.A** **Accessibility and Availability of Medical Records** 1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof. 2. Records are available to providers at each encounter. 3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical and service records.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Record Accessibility and Availability ▪ Provider Participation Agreement ▪ Provider Manual ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider Review Results Notification Letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)	▪	▪
PT9	B.4.14.X.K Appendix	**B.4.14.X.K** **Confidentiality of Patient Information** The organization acts to ensure that the confidentiality of specified patient information and records is protected. 1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records. 2. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas. 3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization. 4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless:	▪ Policies and procedure addressing the following: ➢ Privacy and Confidentiality ➢ Medical Record Storage ➢ Medical Record Standards ➢ Medical Record Accessibility and Availability ▪ Compliance Program Description ▪ Provider Manual ▪ Provider Agreement ▪ Medical Record Audit Tool ▪ Most recent Medical Record Review Audit findings ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Provider review results notification letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)	▪	▪

		a. it is required by law; b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; c. it is necessary in compelling circumstances to protect the health or safety of an individual. 5. Any release of information in response to a court order is reported to the patient in a timely manner. 6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.			
PT10**	6.3.C	**6.3.C** MLTSS Provider Education and Training 1. The Contractor shall work with the State and other contracted MCOs to establish and conduct universal MLTSS provider training. 2. The training curriculum shall include written materials for nursing facilities, assisted living and HCBS providers. This standardized curriculum shall address at a minimum the credentialing processes, service authorizations, continuity of care, community resources, options counseling, claims processes, cultural competency and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board. 3. The Contractor shall conduct provider training with all new MLTSS providers and on an ongoing basis as needed.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers	▪	▪
PT11*	4.7.4	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪

Satisfaction					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
S1*	4.6.2.W	**4.6.2.W** **Member Satisfaction** The State will assess Member satisfaction of Contractor services via the Contractor's adult and child Medicaid Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey version 5.1H, or the version required for NCQA accreditation, including Children with Chronic Conditions (CCC), as well as supplemental questions to be done at the discretion of the State. The Contractor must administer the entire adult and child CAHPS surveys, including CCC, without amendment and follow the instructions contained in the NCQA Specifications for Survey Measures for the current HEDIS year. The Contractor shall fully cooperate with its independent survey administrator such that the MCO's final, analyzed survey results shall be available to the State and/or its designee by June 15th of each contract year.	▪ MCO CAHPS® analysis including improvement actions ▪ State communications regarding results	▪	▪
S2	4.6.2.W	**4.6.2.W** On an annual basis, the Contractor must also ensure that its independent survey administrator submits the final CAHPS raw data to the Agency for Healthcare Research and Quality (AHRQ), and/or entity responsible for maintaining the national CAHPS database and authorizes its use for State level reporting. Contractors shall submit a Workplan by August 15th, or other time period as requested by the DMAHS. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where consumer satisfaction is potentially below quality standards. At the State's discretion, a CAP may be required. The Contractor shall submit corrective actions in a format approved by the State, to identify leading sources of enrollee dissatisfaction, specify additional measurement or intervention efforts developed to address enrollee dissatisfaction, and a timeline indicating when such activities will be completed. Upon the State's request, a status report on the additional measurement or intervention efforts shall be submitted by the Contractor to the State by a date specified by DMAHS.	▪ Corrective Action Plans ▪ Acknowledgement of receipt of submitted corrective action plans from the State ▪ Monitoring of corrective action ▪ Outcome Reports ▪ Quality Improvement Work Plan	▪	▪

		If the Contractor conducts a Member satisfaction survey of its own, it shall send to DMAHS the results of the survey. Additionally, for any CAHPS Survey or other member satisfaction survey conducted by the State and/or its designee, on behalf of the State, the Contractor and/or its vendor shall fully cooperate with the State and/or its designee, and make available all survey related data in a timely manner. Results will be shared with the MCOs, and at the discretion of the State, a Workplan may be requested for areas of enrollee dissatisfaction.			
S3	B.4.14.X.M Appendix	**B.4.14.X.M** **Assessment of Member Satisfaction** If the organization conducts periodic surveys of Member satisfaction with its services, including MLTSS, the following must be included in the surveys. 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors, specialists, MLTSS providers who are trained and experienced in treating people with disabilities. 2. The surveys assess at least a sample of: a. all Medicaid Members; b. Medicaid Member requests to change practitioners and/or facilities; c. disenrollment by Medicaid Members; and d. enrollees receiving MLTSS. 3. As a result of the surveys, the organization: a. identifies and investigates sources of dissatisfaction; b. outlines action steps to follow-up on the findings; and c. informs practitioners and providers of assessment results. 4. The organization reevaluates the effects of the above activities.	▪ Enrollee Satisfaction Survey Results performed by the MCO including those for targeted populations	▪	▪
S4*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion	▪	▪

		dental records, QAPI reports and documents, and financial information.	▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		
S5*	5.16.1.X.1	**5.16.1.X.1** **Periodic Survey of Enrollees** The Contractor shall quarterly survey new enrollees, in person, by phone, or other means, on a random basis to verify the enrollees' understanding of the Contractor's procedures and services availability. Results of the surveys shall be made available to DMAHS and/or the EQRO at the direction of the State for review on request at regularly scheduled onsite and/or virtual visits.	▪ Results of surveys performed by the MCOs. ▪ Quarterly breakout of number of surveys fielded.	▪	▪

Enrollee Rights and Responsibilities

2025 Element	Contract Reference	Contract Requirement Language	Documentation Examples	Met/Not Met	Review Comments
ER1	B.4.14.X.A B.4.14.X.C Appendices	**B.4.14.X.A** **Written Policy on Enrollee Rights** The organization shall have a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of Members: 1. to be treated with respect, dignity, and need for privacy; 2. to be provided with information about the organization, its services, the practitioners providing care, and Members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed; 3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners; 4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence; 5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers; 6. to formulate advance directives; 7. to have access to his/her medical records in accordance with applicable Federal and State laws; 8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect; 9. to be free of hazardous procedures;	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook	▪	▪

		10. to receive information on available treatment options or alternative courses of care; 11. to refuse treatment and be informed of the consequences of such refusal; and 12. to have services provided that promote a meaningful quality of life and autonomy for Members, independent living in Members' homes and other community settings as long as medically and socially feasible, and preservation and support of Members' natural support systems. **B.4.14.X.C** **Written Policy on Enrollee Responsibilities** The organization has to have a written policy that addresses Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for: 1. providing, to the extent possible, information needed by professional staff in caring for the Member; and 2. following instructions and guidelines given by those providing health care services.			
ER2	B.4.14.X.E Appendix	**B.4.14.X.E** **Communication of policies to providers and organization staff** The MCO shall assure a copy of the organization's policies on Members' rights and responsibilities is provided to all participating providers annually. The MCO must monitor and promote compliance with the policies by the Contractor's staff and affiliated providers.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO provider Website Screen Prints ▪ Monitoring Procedures	▪	▪
ER3*	B.4.14.X.F Appendix	**B.4.14.X.F** **Communication of policies to enrollees/Members** Upon enrollment and annually thereafter, Members are provided a written statement that includes information on the following: 1. rights and responsibilities of Members including the specific informational requirements of this section; 2. benefits and services, including MLTSS, included and excluded as a condition of membership, and how to obtain them, including a description of: a. procedures for obtaining services, including MLTSS, including authorization requirements; b. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; c. procedures for obtaining services covered by the Medicaid fee-for-service program; d. the procedures for obtaining out-of-area	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ Website Screen Prints ▪ Member Letters	▪	▪

		coverage; and e. policies on referrals for specialty and ancillary care. 3. provisions for after-hours and emergency coverage and for MLTSS Members provision of key contact information such as the emergency after hours number with immediate access to a Contractor's staff Member who has access to the Member's plan of care and who can make immediate service authorizations and perform care coordination functions; 4. the organization's policy and procedures on referrals for specialty care, ancillary services and MLTSS; 5. charges to Members, if applicable, including: a) policy on payment of charges; b) co-payments, patient pay liability and fees for which the Member is responsible; and c) what to do if a Member receives a bill for services or is non-compliant with payment of co-payments, patient pay liabilities or other fees. 6. procedures for notifying those Members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers. 7. procedures for appealing decisions adversely affecting the Member's coverage, benefits, or relationship to the organization; 8. procedures for changing providers; 9. procedures for disenrollment; and 10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.			
ER4	B.4.14.X.J Appendix	**B.4.14.X.J** **Written information for Members** 1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood at a 5th grade reading level using a font size no smaller than 12 point. All written materials for potential enrollees and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point. 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.	▪ Enrollee educational materials in different languages ▪ Approval letters from the State on enrollee educational literature ▪ Population Study Results ▪ Written information in various languages ▪ Readability Scores	▪	▪
ER5	B.4.14.X.L Appendix	**B.4.14.X.L** **Treatment of Minors and Individuals with Disabilities** The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.	▪ Policies and Procedures addressing the following: ➢ Treatment of Minors and Individuals with Disabilities	▪	▪

			▪ Program Descriptions for the following: ➢ Care Management ➢ Quality Improvement ➢ Utilization Management		
ER6**	B.4.14.X.B B.4.14.X.D Appendices	**B.4.14.X.B** **Written policy on MLTSS Member rights** - The organization has a written policy that recognizes the following rights of MLTSS Members: 1. To request and receive information on choice of services available; 2. Have access to and choice of qualified service providers; 3. Be informed of your rights prior to receiving chosen and approved services; 4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability; 5. Have the right, as a resident of an MLTSS community, to have a key to lock/unlock the home and bedroom doors, to have visitors of the Member's choosing, make and receive phone calls, make independent schedules, and have access to food at any time, unless otherwise determined in a documented person-centered process; 6. Have access to appropriate services that support your health and welfare; 7. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made; 8. To make decisions concerning your care needs; 9. Participate in the development of and changes to the Plan of Care; 10. Request changes in services at any time, including add, increase, decrease or discontinue; 11. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under the Plan of Care; 12. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers; 13. Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings; 14. Be informed of all the covered/required services you are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility; 15. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non-payment to the facility from available income as reported on the statement of available income for Medicaid payment.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook	▪	▪

		16. Have your health plan protect and promote your ability to exercise all rights identified in this document. 17. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian. **B.4.14.X.D** **Written policy on MLTSS Member responsibilities** - The organization has a written policy that addressees Members' responsibility for cooperating with those providing services. This written policy addresses Members' responsibility for: 1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care; 2. Understand your health care needs and work with your Care Manager to develop or change goals and services; 3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services; 4. Ask questions when additional understanding is needed; 5. Understand the risks associated with your decisions about care; 6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager; 7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and 8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).			
ER7**	4.6.1.B.2	**4.6.1.B.2** Provide for MLTSS to allow an individual to maintain themselves in the least restrictive, most integrated setting of their choice, to the extent possible. Such service provision shall promote the enrollee's ability to age in place through coordination of formal and informal supports to address the assessed needs of the individual.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ MLTSS Member Handbook ▪ Care Management	▪	▪
ER8*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion.	▪	▪

			▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		
Member Disenrollment					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
Sub-heading	5.10.2	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE ENROLLEE'S REQUEST**			
MD1	5.10.2.A 5.10.2.A.1	**5.10.2.A** **5.10.2.A.1** A. An individual enrolled in a Contractor's plan may elect to change Contractors during an Annual Open Enrollment Period from October 1 to November 15. 1. All enrollees are subject to the Annual Open Enrollment Period and may initiate disenrollment from one Contractor and transfer to another Contractor for any reason during the first ninety (90) days after the latter of the date the individual is enrolled or the date they receive notice of enrollment with a new Contractor and during the period DMAHS has identified for the Annual Open Enrollment Period without cause. a. An individual may transfer from the Contractor's plan upon automatic re-enrollment if he or she was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility has caused the individual to miss the Annual Open Enrollment Period.	▪ Policies and Procedures addressing the following: ▪ Enrollee's right to change MCO – open enrollment ▪ Member Handbook	▪	▪

MD2	5.10.2.A.2	**5.10.2.A.2** 2. An enrollee may initiate disenrollment and a transfer to another Contractor's plan at any time if they meet one of the good cause reasons defined in this contract. a. Good cause reasons for disenrollment and transfer shall include, unless otherwise defined by DMAHS: i. Failure of the Contractor to provide services including physical access to the enrollee in accordance with the terms of this contract. ii. Enrollee has filed a grievance/appeal with the Contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law. iii. Documented grievance/appeal, by the enrollee against the Contractor's plan without satisfaction. iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area. v. Poor quality of care. vi. Enrollee is eligible to participate through DCP&P/DCF. vii. Enrollee has met NF LOC and is MLTSS eligible. viii. Other for cause reasons pursuant to 42 CFR 438.56.	▪ Policies and Procedures addressing the following: ▪ Enrollee's right to change MCO for good cause ▪ Member Handbook	▪	▪
Sub-heading	5.10.3	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE CONTRACTOR'S REQUEST AND REPORTING OF ENROLLEE NON-COMPLIANCE**			
MD3	5.10.1.A 5.10.3.A 5.10.3.A.1	**5.10.1.A** A. Non-discrimination. Disenrollment from Contractor's plan shall not be based in whole or in part on an adverse change in the enrollee's health, on any of the factors listed in Article 7.8 (race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap or disability) or on amounts payable to the Contractor related to the enrollee's participation in the Contractor's plan. **5.10.3.A**	▪ Policies and Procedures addressing the following: ▪ Nondiscrimination ▪ Criteria for disenrollment request ▪ Member Handbook	▪	▪

		Criteria for Contractor Disenrollment Request. The Contractor may recommend, with written documentation to DMAHS, the disenrollment of an enrollee. (See Section B.5.1 of the Appendices, for the applicable Notification forms and amendments thereto). In no event may an enrollee be disenrolled due to health status, need for health services or a change in health status. Enrollees may be disenrolled in any of the following circumstances: **5.10.3.A.1** The Contractor becomes aware that the enrollee falls into an aid category that is not set forth in Article 5.2 of this contract, has become ineligible for enrollment pursuant to Article 5.3.1 of this contract, or has moved to a residence outside of the enrollment area covered by this contract.			
MD4	5.10.3.A.2	**5.10.3.A.2** 2. The Contractor learns that the enrollee is residing outside the State of New Jersey for more than 30 days. This does not apply to: a. situations when the enrollee is out of State for care provided/authorized by the Contractor. b. full-time students, or c. Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P. For an MLTSS enrollee who has moved out of state; the Contractor must comply with all requirements set forth in article 9.3.5 and 9.3.6. In addition, the Contractor shall certify that outreach to providers has occurred and a query of Medicaid/MLTSS services was completed and member has not been authorized for, or received any Medicaid services for the last 30 days. The Contractor shall then submit the LTC-50 Unable to Contact/ Inaccessible Disenrollment form to DoAS as per instructions	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook	▪	▪
MD5	5.10.3.A.3	**5.10.3.A.3** 3. If a Member is admitted to an out of state NF or SCNF by the Contractor, and the Member is not returning to New Jersey.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook	▪	▪
MD6	5.10.3.A.4	**5.10.3.A.4** 4. Upon death of the enrollee.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request	▪	▪
MD7	5.10.3.A.5	**5.10.3.A.5** 5. An enrollee is institutionalized in a facility other than a NF/SCNF.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request	▪	▪

			▪ Member Handbook		
MD8	5.10.3.A.6	**5.10.3.A.6** 6. Incarceration of an enrollee (other than a DSNP enrollee) shall result in suspension of the Contractor's capitation payment and provision of Managed Care services to the enrollee from the day following the start of incarceration through the day of release. During this period, the incarcerated enrollee's benefits shall be suspended, but enrollee shall not be disenrolled. The enrollee shall remain a Member of the Contractor.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook	▪	▪
MD9	5.10.3.B	**5.10.3.B** B. Criteria for Non-Compliant Enrollees. The Contractor shall submit quarterly reports that includes written documentation to DMAHS of enrollees determined by the Contractor to be non-compliant. The documentation should include detail of any willful actions of the enrollee that are inconsistent with membership in the Contractor's plan. The Contractor shall provide DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include but are not limited to: persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude an enrollee's right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for non-emergency care; willful refusal to comply with reasonable approval for non-emergency care; willful refusal to comply with reasonable administrative policies of the Contractor, fraud, or making a material misrepresentation to the Contractor. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socio-economic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs. (See Article 4.5 regarding special needs enrollees.) The DMAHS shall review each quarterly report and each case may require an in-depth review by State staff, including but not limited to patient and provider interviews, medical record review, and home assessment to determine with the enrollee what plan of action would serve the best interests of the enrollee (and family as applicable.)	▪ Policies and Procedures addressing the following: ▪ Criteria for non-compliant enrollees ▪ Example of quarterly report to DMAHS of non-compliant enrollees ▪ Member Handbook	▪	▪
MD10	5.10.2.D	**5.10.2.D** D. Effective Date. The effective date of disenrollment or transfer shall be no later than the first day of the month immediately following the full calendar month the disenrollment is initiated by DMAHS. If DMAHS fails to make a disenrollment determination for initiated disenrollments that meet the disenrollment terms under this Contract, the disenrollment is considered approved. Notwithstanding anything herein to the contrary, the remittance tape, along with any changes reflected in the register or agreed upon by DMAHS and the Contractor in writing, shall serve as official notice to the Contractor of disenrollment of an enrollee from the Contractor's plan.	▪ Policies and Procedures addressing the following: ▪ Effective date of disenrollment or transfer ▪ Report showing effective date of disenrollment or transfer	▪	▪
Sub-heading	9.4.2	**VOLUNTARY WITHDRAWAL FROM MANAGED LONG TERM SERVICES AND SUPPORTS**			

MD11***	9.4.2.A	**9.4.2.A** A. MLTSS enrolled participants who indicate they would like to withdraw from MLTSS are required to be counseled by their Managed Care Organization Care Manager (MCO CM). This counseling shall be face-to-face with the participant. If the member declines a face-to-face visit, the counseling may occur via telephone. The MCO CM will: 1. Counsel the participant that withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 2. Ensure the participant has full understanding that if they were not receiving Medicaid State Plan services prior to enrollment into MLTSS, they may NOT be eligible for NJ FamilyCare upon withdraw from MLTSS; 3. Counsel the participant on what MLTSS and State Plan services will be lost or unavailable as a result of the withdrawal; 4. Counsel the participant on how to ensure they remain eligible to receive NJ FamilyCare; 5. Counsel the participant on other services or programs for which they may be eligible, including information about contacting the Aging and Disability Resource Connection (ADRC); 6. Counsel the participant on how to access MLTSS services in the future; and, 7. Ensure the participant understands the withdrawal process, timeframes, outcomes, and signs the consent form.	▪ Policies and Procedures addressing the following: ▪ Counseling of MLTSS enrollees requesting withdrawal from MLTSS ▪ MLTSS Handbook	▪	▪
MD12***	9.4.2.B	**9.4.2.B** B. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork. The participant will be asked to sign the NJ Department of Human Services Voluntary Withdrawal Form indicating their understanding and consent to withdraw from MLTSS.	▪ Policies and Procedures addressing the following: ▪ Documentation of discussion with enrollee regarding withdrawal from MLTSS request ▪ Completion of required paperwork for withdrawal request ▪ Example of documentation of enrollee discussion regarding MLTSS withdrawal	▪	▪

MD13***	9.4.2.C	**9.4.2.C** C. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the withdrawal request to the Central Office of The Division of Aging Services (DoAS), using the Voluntary Withdrawal Form found at Appendix B.5.1, within three business days of completion. DoAS will process the voluntary withdrawal within ten business days of receipt. The Contractor shall validate the disenrollment action in the eMEVS system.	▪ Policies and Procedures addressing the following: ▪ MLTSS Care Management Case Closure standards	▪	▪
MD14***	9.4.2.D	**9.4.2.D** D. The withdrawal request must specify the member's address, phone number, and legal representative (if applicable) for potential follow up counseling by the Office of Community Choice Options (OCCO). The Program Status Code (PSC) as identified in the State's MMIS systems is to be provided by the MCO and indicated on the withdrawal request.	▪ Policies and Procedures addressing the following: ▪ Requirements for MLTSS withdrawal request	▪	▪
MD15***	9.4.2.E	**9.4.2.E** E. The Contractor shall provide the member with the voluntary withdrawal form found in Appendix A.9.4.2 as well as a copy of the fully executed form.	▪ Policies and Procedures addressing the following: ▪ Providing member with voluntary withdrawal form ▪ Copy of voluntary withdrawal form	▪	▪
MD16***	9.4.2.F	**9.4.2.F** F. Upon receipt, DoAS shall terminate the MLTSS clinical eligibility determination in the State's MMIS system. DoAS will forward the withdrawal request indicating clinical eligibility determination termination to the Contractor, DMAHS Health Benefits Coordinator, DMAHS County Operations Office, and the County Social Service Agency.	▪ Policies and Procedures addressing the following: ▪ Facilitation of MLTSS reenrollment	▪	▪
Sub-heading	9.4.3	**DISENROLLMENT DUE TO MEMBER NON-COMPLIANCE WITH MLTSS CARE MANAGEMENT REQUIREMENTS**			
MD17***	9.4.3.A	**9.4.3.A** A. The Contractor shall include notice of member requirement to comply with care management requirements including face to face visits and reassessment of clinical eligibility. These requirements must be reviewed during the assessment for MLTSS, if appropriate, upon enrollment, and annually thereafter.	▪ Policies and Procedures addressing the following: ➢ Member requirements to comply with care management requirements, including review of requirements during MLTSS assessment upon enrollment and annually thereafter ▪ Notice to members of requirements to comply	▪	▪

			with care management requirements		
MD18***	9.4.3.B	**9.4.3.B** B. The Contractor shall include notice of enrollment and disenrollment processes and procedures in the Member handbook as outlined in 5.8.2.	▪ Member handbook section on enrollment and disenrollment processes and procedures	▪	▪
MD19***	9.4.3.C	**9.4.3.C** C. The Contractor shall develop and implement a policy and process for instances in which the MLTSS member declines to consent to care management services. "Decline to consent to care management services" shall be defined as an MLTSS Member who declines the required clinical eligibility reassessment process or two consecutive face-to-face visits with at least two additional outreach attempts by the Contractor's staff to notify the Member of their non-compliance, counsel on the voluntary disenrollment process, and potential for Member's involuntary disenrollment from MLTSS and potential loss of Medicaid eligibility.	▪ Policies and Procedures addressing the following: ➢ Situations when the MLTSS member declines to consent to care management services	▪	▪
MD20***	9.4.3.D	**9.4.3.D** D. Members who decline to consent to clinical eligibility reassessment or face to face visits after counseling and a minimum of two contacts to obtain consent by the Contractor or OCCO, the Contractor or OCCO, shall send written notification of the intent to terminate MLTSS eligibility no sooner than 20 business days from the date of notification due to lack of consent to care management services. The written notification of intent to request involuntary disenrollment will inform the member that: 1. The member may voluntarily change health plans if they wish to receive care management services and continue to receive MLTSS services 2. The member may voluntarily withdrawal from MLTSS if they do not wish to receive care management and MLTSS services 3. Withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 4. The individual is required to establish Medicaid status through the County Social Service Agency. a. The MCO Care Manager shall provide county specific contact information and assist participant with this outreach upon request. 5. Provide information and contact numbers for community resources including the Aging and Disability Resource Connection (ADRC); 6. Provide information on how to apply for MLTSS services in the future;	▪ Policies and Procedures addressing the following: ➢ Notice to terminate MLTSS eligibility when the member declines to consent to clinical eligibility reassessment or face-to-face visits ➢ Notice to include the six requirements for notice of involuntary disenrollment to member ▪ Sample notice of intent to terminate MLTSS eligibility	▪	▪
MD21***	9.4.3.E	**9.4.3.E** E. If the member requests voluntary disenrollment, the MCO shall process the request in accordance with established protocols.	▪ Policies and Procedures addressing the following: ➢ Process for when the member requests	▪	▪

			voluntary disenrollment		
MD22***	9.4.3.F	**9.4.3.F** F. If the member fails to respond to the notification or fails to make arrangements to comply with the requirements, the MCO Care Manager Supervisor shall submit the Request for Involuntary Disenrollment Form to the Division of Aging Services (DoAS) MLTSS Operations within three business days of completion.	▪ Policies and Procedures addressing the following: ➢ If member fails to respond to termination notification, MCO shall submit request for Involuntary Disenrollment form to the DoAS ▪ Sample of Involuntary Disenrollment Form	▪	▪
MD23***	9.4.3.G	**9.4.3.G** G. Upon receipt of the Involuntary Disenrollment request, the DoAS shall send the Member the Intent to Involuntarily Disenroll letter within five (5) business days. If the participant fails to respond within ten business days, the DoAS shall send a Notice of Disenrollment from MLTSS letter which will include notice of the participant's Medicaid Fair Hearing Rights. The termination of clinical eligibility will be entered by DoAS 60 business days after the date of the letter which will trigger disenrollment from MLTSS based on the standard enrollment cycle. DoAS will notify DMAHS Managed Care Account Coordinator Unit, DMAHS County Operations Office, and the MCO Care Manager designee of the clinical eligibility termination within two (2) business days of entry.	▪ Policies and Procedures addressing the following: ➢ DoAS Process for involuntary disenrollment request	▪	▪
MD24***	9.4.3.H	**9.4.3.H** H. If the participant contacts DoAS or the MCO indicating they wish to continue with MLTSS and are in agreement with complying with the requirements, the recipient of the request shall notify the appropriate entity, DoAS or the MCO. The MCO MLTSS Care Manager shall initiate a face to face visit within ten (10) business days of notification.	▪ Policies and Procedures addressing the following: ➢ Situations when the participant wishes to continue with MLTSS ➢ Initiation of face to face visits within ten (10) days of notification	▪	▪
MD25***	9.4.3.I	**9.4.3.I** I. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork.	▪ Policies and Procedures addressing the following: ➢ Care Manager responsibility for documenting discussion with participant and completing required paperwork	▪	▪

			➢ Sample of CM documentation of participant discussion		
MD26***	9.4.3.J	**9.4.3.J** J. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the disenrollment request to the Regional Office of Community Choice Options via the "DHS Participant Termination Request Due to Non-Compliance with Reassessment" Form within three business days of completion:	▪ Policies and Procedures addressing the following: ➢ MLTSS Care Management Case Closure standards ▪ Sample of DHS Participant Termination Request Due to Non-Compliance with Assessment form	▪	▪
MD27***	9.4.3.K	**9.4.3.K** K. The disenrollment request certifies that outreach, counseling, and notification has occurred without response or appeal.	▪ Policies and Procedures addressing the following: ➢ Process when outreach, counseling, and notification has occurred without response or appeal ▪ Sample documentation of outreach, counseling, notification	▪	▪
MD28***	9.4.3.L	**9.4.3.L** L. The disenrollment due to member non-compliance of determination of continued clinical eligibility is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal processes. Contact with the member and counseling must occur prior to sending the Involuntary Disenrollment. The member can stop the pending disenrollment process by consenting to the reassessment requirements.	▪ Policies and Procedures addressing the following: ➢ Requirement that disenrollment for non-compliance is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal ➢ Member can pend disenrollment process by consenting to reassessment requirements	▪	▪
MD29*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate.	▪	▪

			▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		

Credentialing and Recredentialing					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
CR1	4.8.5.C	**4.8.5.C** C. The Contractor shall collect and maintain, as part of its credentialing process, through special survey process, or other means information from licensed practitioners including pediatricians and pediatric subspecialists about the nature and extent of their experience in serving children with special health care needs including developmental disabilities.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing ▪ Entire Year of the most recent Credentialing/Recredentialing Committee Meeting Minutes ▪ Process for collecting data on a provider's experience in treating children with special healthcare needs including how it maintains and updates the information ▪ Survey for collecting provider experience in treating children with special healthcare needs including examples ▪ Documentation showing monitoring of the	▪	▪

			credentialing and recredentialing timeliness		
CR2*	4.6.1.C.5	**4.6.1.C.5** **Provider Credentialing.** New Jersey requires a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Before any provider/subcontractor may become part of the Contractor's network, that provider/subcontractor shall be credentialed by the Contractor. The Contractor must comply with N.J.A.C. 11:24C-1 et seq. and Standard IX of New Jersey QAPI Standards, (Section B.4.14 of the Appendices). For provider types eligible to use the Council for Affordable Quality Healthcare (CAQH) credentialing application who are applying for initial credentialing, the Contractor must accept the CAQH application; for those providers, the Contractor shall not require the provider to resubmit any information that is already included within the CAQH application. Additionally, the Contractor's credentialing procedures shall include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The Contractor shall obtain federal and State lists of suspended/debarred providers from the appropriate agencies and comply with the specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35 and found at B.7.35. The Contractor shall ensure providers comply with N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional as well as a fingerprint-based background check for all Providers and their employees who provide face-to-face services to Members, when required by statute or regulation. The Contractor's process for credentialing shall include notification to providers of errors in the credentialing application within three (3) business days of receipt. The Contractor's credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing ▪ Entire Year of the most recent Credentialing/Recredentialing Committee Meeting Minutes ▪ Ongoing monitoring of State and federal sanctions and suspensions ▪ File review of provider terminated from MCO due to suspension of licensure to practice by CMS or the State of New Jersey ▪ Monitoring of MLTSS providers for suspension	▪	▪
Sub-heading	B.4.14.IX Appendix	**B.4.14.IX** **Credentialing and Recredentialing** The QAPI contains the following provisions to determine whether physicians, other health care professionals and other providers of services to the Contractor's enrollees meet all applicable state licensing standards, Contractor participation or credentialing criteria and are qualified to provide the care or services for which they have been			

		contracted. (See Article 3.3.2, 4.6.1, 4.8.5, and 7.4E for additional detail regarding credentialing and recredentialing.)			
CR3	B.4.14.IX.A Appendix	**B.4.14.IX.A** **Written Policies and Procedures** The managed care organization has, at a minimum, written policies and procedures consistent with NCQA standards and State requirements, to address the following: 1. Types of providers, including organizational providers such as Hospitals, Home Health Agencies, NFs, SCNFs, Free-standing surgical centers, ambulatory care centers, inpatient Behavioral Health providers, and residential care settings, to credential and (re)credential, 2. The verification sources used, 3. Criteria for (re)credentialing, 4. Process for making (re)credentialing decisions, 5. Process for managing credentialing files that meet established criteria, 6. Process for delegating credentialing activities, 7. Process for ensuring (re)credentialing activity is conducted in a non-discriminatory manner, 8. Process for notifying providers if information collected during the (re)credentialing process substantially varies from information they provided as part of the (re)credential process, 9. Process for ensuring providers are notified of the (re)credentialing decision within 60 days of the Committee's decision, 10. Medical Director or other designated physician's direct responsibility and participation in the credentialing program, 11. Process for ensuring confidentiality of information obtained in the (re)credentialing process, except as otherwise provided by law, 12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including education, training, board certification and specialty and 13. Process for ensuring that organizational and non-traditional providers are: • In good standing with State and Federal regulatory bodies • Reviewed and approved by a recognized accrediting body, based on requirements outlined in the MLTSS Services Dictionary found in Appendix B.9.0.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing	▪	▪
CR4	B.4.14.IX.B Appendix	**B.4.14.IX.B** **Oversight by Governing Body** The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing ▪ Quality Improvement Program Description	▪	▪

			▪ Credentialing/Recredentialing Committee Charter ▪ Entire Year of the most recent Credentialing/Recredentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and recredentialing process including timeliness		
CR5	B.4.14.IX.C Appendix	**B.4.14.IX.C** **Credentialing Entity** The plan shall designate a credentialing committee or other peer review body that includes participating providers from the Contractor's network, which makes recommendations regarding credentialing decisions.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing ▪ Credentialing/Recredentialing Committee Charter ▪ Entire Year of the most recent Credentialing/ Recredentialing Committee Meeting Minutes	▪	▪
CR6	B.4.14.IX.D Appendix	**B.4.14.IX.D** **Scope** The plan identifies those providers who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, behavioral health clinicians, facilities and providers of MLTSS included in the Contractor's literature for Members, as an indication of those providers whose service to Members is contracted or anticipated.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing ▪ Credentialing Committee Charter	▪	▪
CR7	B.4.14.IX.E Appendix	**B.4.14.IX.E** **Process** The initial credentialing process obtains and reviews verification of the following information, at a minimum: 1. the provider holds a current valid license to practice; 2. a dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it; 3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable;	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing Process ▪ Credentialing Desk-Top Procedure ▪ Credentialing Application ▪ Practitioner Office Site Audit Tool		

		4. work history; 5. professional liability claims history; 6. good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.) 7. the providers hold current, adequate malpractice insurance according to the plan's policy; 8. any revocation or suspension of a State license or DEA number; 9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and 10. any censure by the State or County Medical Association. 11. The organization requests information on the provider from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate licensing board, depending on the provider type. 12. The application process includes a statement by the applicant regarding: a. any physical or mental health problems that may affect current ability to provide health care; b. any history of chemical dependency/ substance use disorder; c. history of loss of license and/or felony convictions; d. history of loss or limitation of hospital privileges or disciplinary activity; and e. an attestation to correctness/ completeness of the applications. This information should be used to evaluate the practitioner's current ability to practice. 13. There is an attestation from each potential primary care provider's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.	▪ Regulatory and Accreditation Verification Source Table ▪ Documentation showing monitoring of the credentialing timeliness		
CR8	B.4.14.IX.F Appendix	**B.4.14.IX.F** **Recredentialing** A process for the periodic re-verification of credentials (recredentialing, reappointment, or recertification) described in the organization's policies and procedures. 1. There is evidence that the procedure is implemented at least every three years or more frequently, as necessary, to be in accordance with the providers' licensing requirements. 2. The Contractor shall develop and implement a mechanism for monitoring of critical incident events and grievances related to the care and/or services received that	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Recredentialing Process ▪ Recredentialing Desk Top Procedures		

		identified trends and determine a threshold at which an off-cycle recredentialing event would be triggered. 3. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all providers, to decide whether to renew the participating provider agreement. At a minimum, the recredentialing, recertification or reappointment process is organized to verify current standing on items listed in "E-1" through "E-7" above and item "E-12" as well. 4. The recredentialing, recertification or reappointment process also includes review of data from: a. Member grievances; b. results of quality reviews; c. performance indicators; d. utilization management; e. critical incidents; and f. re-verifications of hospital privileges and current licensure.	▪ Documentation showing monitoring of recredentialing timeliness ➢ Ongoing monitoring of critical incidents and grievances and process to trigger off-cycle recredentialing Practitioner-Specific: ➢ Member Grievance Reports ➢ Quality of Care Concerns ➢ Performance Indicators ➢ Utilization Management ➢ Member Satisfaction ➢ Critical incident report monitoring		
CR9***	4.6.1.C.7	**4.6.1.C.7** For MLTSS providers the Contractor shall: a. Have a credentialing/ process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/recredentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members. c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members. i. Have a credentialing/recredentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/recredentialing requirements	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing and Recredentialing of MLTSS providers ▪ Entire Year of the most recent Credentialing/Recredentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and Recredentialing timeliness ▪ Criminal background checks		

		in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the Criminal History Record Information (CHRI) during credentialing process. iii. At minimum, have a recredentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI). iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs. v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI. vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must undergo state CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review. vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or recredentialing. viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from las/regulation.	▪ Monitoring of continued licensure/and or certification ▪ Monitoring of sanctions		

		ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof. x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract. xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute.			
CR10*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪
Utilization Management					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
UM1	4.2.4.F	**4.2.4.F** Drug Utilization Review (DUR) Program. In accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October 1, 2019, requiring the Contractor to implement provisions intended to monitor opioid and antipsychotic prescription utilization, the Contractor shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Contractor shall include review of Mental Health/Substance Use Disorder drugs, opioid and antipsychotic drugs in its DUR program. The State or its agent shall provide its expertise in developing review protocols and shall assist the Contractor in analyzing	▪ Policies and Procedures addressing the following: ➢ Formulary Denials ➢ Prior Authorization Requests ➢ Type of Drug Denials ➢ Denial Criteria ➢ That scripts written by mental health/substance use disorder providers do not require prior authorization	▪	▪

		MH/SUD, opioid and antipsychotic drug utilization. Results of the review shall be provided to the State or its agent and, where applicable, to the Contractor's network providers. The State or its agent will take appropriate corrective action to report its actions and outcomes to the Contractor.	➢ Pharmacy Prior Authorization ▪ Drug Utilization Review Program Description ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Various retrospective reports looking at the utilization of drugs in relationship to fraud and abuse (narcotics) over/under utilization of specific drugs, and mental health/substance use disorder drugs ▪ Various reports revealing clinical conflicts as related to drug interactions, drug-allergy conflicts, drug-disease conflicts, cumulative early refill, therapeutic duplication, drug exceeding maximum daily dosage, drug under minimum daily dosage, drug-age conflict, drug-gender conflict and duration of therapy ▪ Initiatives Developed to Address Deficiencies including Outcomes		
UM2	4.6.1.C.3	**4.6.1.C.3** Enrollee Rights and Responsibilities. Shall include the right to the Medicaid Fair Hearing Process for Medicaid enrollees.	▪ Policy and Procedure addressing the following: ➢ Medicaid Fair Hearing Process ➢ Adverse Determinations ➢ Member Appeals	▪	▪

			▪ Certificate of Coverage ▪ Cited page/s in the Provider Manual ▪ MCO Website ▪ Notice of Action ▪ Member Handbook		
Sub-heading	4.6.4 B.4.14.XIII Appendix	**4.6.4** **B.4.14.XIII** The Contractor shall develop a written Utilization Review Plan that includes all standards described in the NJ QAPI Standards.			
UM3	4.6.4.A B.4.14.XIII Appendix	**4.6.4.A** Utilization Review Plan. The Contractor shall develop a written Utilization Review Plan that includes all standards described in the New Jersey QAPI Standards (See Section B.4.14 of the Appendices) and the standards provided in Article 4.4 for MLTSS and DDD behavioral health utilization management. Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. **B.4.14.XIII** **A. written program description** - The organization has a written utilization management program description which includes at a minimum: • procedures to evaluate medical necessity and the criteria and tools used for MLTSS Members • procedures to evaluate functional care needs and authorize services to address those needs • information sources and the process used to review and approve the provision of services • the mechanism and metrics used to evaluate the utilization management program effectiveness **B. scope** - The program has mechanisms to detect underutilization as well as overutilization.	▪ Utilization Management Program Description ▪ QI Work Plan ▪ CAHPs reports ▪ Provider Surveys ▪ Documentation for Delegated Entities ➢ Policies and Procedures ➢ Workflows ➢ MCO's role in oversight of Delegated Entities	▪	▪
UM4		**In 2019, this element (UM4) was removed – Contract requirements will be addressed under UM3.**			
UM5	4.6.4.A.10	**4.6.4.A.10** **Prohibited Actions** Neither the Contractor's UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination.	▪ Policies and Procedures addressing the following: ➢ Member and Provider Appeals ➢ Prior Authorizations	▪	▪

		Additionally, neither the Contractor's UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.	➢ Adverse Determinations ▪ Adverse Determination Letters ▪ Provider Manual ▪ Member Handbook		
UM6	4.6.4.B	**4.6.4.B** **Prior Authorization** The Contractor shall have policies and procedures for prior-authorization and have in effect mechanisms to ensure consistent application of service criteria for authorization decisions. All PA requests shall be assigned a unique identification number to enable tracking requests and for reporting purposes.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ UM Program Description ➢ Clinical Criteria for UM decisions ➢ Inter-Rater Reliability Testing Policy and Procedure ▪ Inter-Rater Reliability Testing Results	▪	▪
UM7	4.6.4.B	**4.6.4.B** Prior authorization shall be conducted by a currently licensed, registered or certified health care professional, including a registered nurse or a physician who is appropriately trained in the principles, procedures and standards of utilization review.	**Assessment will also include a file review to verify compliance.** **Requires a State-approved policy and procedure.** ▪ QI Program Description ▪ UM Program Description ▪ Inter-rater Reliable Policy and Procedure ▪ UM Reviewer Job Description ▪ Physician-Reviewer Job Description ▪ Resumes/Bios ▪ Pharmacy personnel making authorizations for pharmaceuticals job description		
Sub-heading	4.6.4.B	**4.6.4.B** The following timeframes and requirements shall apply to all **prior authorization** determinations:			

UM8	4.6.4.B.1	**4.6.4.B.1** **Routine determinations** Prior authorization determinations for non-urgent services shall be made and a notice of approved determination provided by telephone or in writing to the provider within fourteen (14) calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352, 42 CFR 438.404(c), NJAC §11:24, and the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq. a. The dental prior authorization shall be active for a minimum of six (6) months. b. When home health, PCA, or PDN services are authorized, any subsequent reduction, suspension, or termination of these services must be the result of a reassessment, with that reassessment applying the same standards and (where applicable) using the same tool used in the original assessment. Any reduction, suspension, or termination of these services cannot solely be triggered by the end date of an existing authorization..	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification	▪	▪
UM9	4.6.4.B.2	**4.6.4.B.2** **Urgent determinations** Prior authorization determinations for urgent services shall be made within twenty-four (24) hours of receipt of the necessary information, but no later than seventy-two (72) hours after receipt of the request for service. Written notification shall be provided in accordance with the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq., within twenty four (24) hours of the decision.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification	▪	▪
UM10	4.6.4.B.3	**4.6.4.B.3** **Determination for Services that have been delivered.** Determinations involving health care services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports	▪	▪

			▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification		
UM11	4.6.4.B.4	**4.6.4.B.4** **Adverse Determinations** A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination in all adverse determinations. A NJ licensed orthodontist shall make the final determination in all adverse determinations for comprehensive orthodontic treatment service requests.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Consultant/Medical Peer Review Process ▪ UM Program Description	▪	▪
UM12	4.6.4.B.5	**4.6.4.B.5** **Continued/Extended Services** A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's health care provider, by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of an enrollee currently receiving inpatient hospital service or emergency room care, the Contractor shall make the determination involving continued or extended health care services within 24 hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. For services that require multiple visits, a series of tests, etc. to complete the service, the authorized time period shall be adequate to cover the anticipated span of time that best fits the service needs and circumstances of each individual enrollee.	▪ Policies and Procedures addressing the following: ➢ Concurrent Review ➢ Authorization Timeframes ▪ Excel spreadsheet of concurrent review activity with request date, decision date, date of consultation with referring provider, date of enrollee and provider notification	▪	▪
UM13	4.6.4.B.6	**4.6.4.B.6** **Reconsiderations** The Contractor's policies and procedures for authorization shall include consulting with the requesting provider when appropriate. The Contractor shall have policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring provider. Determinations in such cases shall be made within the timeframes established for initial considerations.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ UM Program Description	▪	▪
UM14	4.6.4.B.7	**4.6.4.B.7** The Contractor shall provide written notification to enrollees and/or, where applicable, an authorized person at the time of denial, deferral or modification of a	▪ Policies and Procedures addressing the following:	▪	▪

		request for prior approval to provide a medical/dental/behavioral health/MLTSS service(s) when the following conditions exist: a. The request is made by a medical/dental or other health care provider who has a formal arrangement with the Contractor to provide services to the enrollee. b. The request is made by the provider through the formal prior authorization procedures operated by the Contractor. c. The service for which prior authorization is requested is a Medicaid covered service for which the Contractor has established a prior authorization requirement. d. The prior authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring, pending or modifying (as allowed) the service requested but prior to the point at which the enrollee must initiate the Contractor's appeal process.	➢ Prior Authorizations ➢ Adverse Determinations ▪ Notice of Action ▪ Tracking System		
UM15	4.6.4.B.8	**4.6.4.B.8** **Notice of Action.** Notice of action shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. The member, member's authorized representative, and provider acting on behalf of a member with the member's written consent (if the latter is applicable) shall receive written notice of any adverse determination within two business days of said determination. The written notice shall be generated on the date of the determination. In the case of expedited appeal process, the Contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, and the enrollee (or their authorized representative) of the following: a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other coverage determination; b. The enrollee's rights to, and method for obtaining, an external (IURO) appeal and/or Fair Hearing to contest the denial, deferral or modification action; c. The enrollee's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, or a friend or other spokesperson designated in writing as an authorized representative; d. The action taken or intended to be taken by the Contractor on the request for prior authorization and the reason for such action including clinical or other rationale and the underlying contractual basis or Medicaid authority; e. The name and address of the Contractor; f. Notice of internal (Contractor) appeal rights and instructions on how to initiate such appeal; g. Notice of the availability of the clinical or other review criteria relied upon to make the determination;	▪ Policies and Procedures addressing the following: ➢ Adverse Determinations ▪ Notice of Action Letter templates – Enrollee and Provider ▪ Examples of Notice of Action Letters – Enrollee and Provider	▪	▪

		h. The notice to the enrollee shall inform the enrollee that he or she may file an appeal concerning the Contractor's action using the Contractor's appeal procedure prior to or concurrent with the initiation of the State hearing process; i. The Contractor shall notify enrollees, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352 42 CFR 438.404(c), and in NJAC §11:24-8.3; j. The enrollee's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal.			
UM16*/**	5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.4 4.6.4.B.5 4.6.4.B.7 4.6.4.B.8	**5.8.2.F** **Grievances and Appeals** 1. Procedures for resolving grievances, as approved by the DMAHS including a member facing explanation of the process for filing a grievance. 2. A description of the appeal procedures to be used to resolve an adverse benefit determination, including: the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in adverse benefit determination appeals; the time frames and circumstances for expedited and standard appeals; the right to appeal an adverse benefit determination; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 3. The Contractor shall notify all enrollees in their primary language of their rights to file grievances and appeals by the Contractor. 4. An explanation that, in addition to the MCO Appeal process, Medicaid/NJ FamilyCare A enrollees, and NJ FamilyCare ABP enrollees have the right to a Fair Hearing (which must be requested within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal) with DMAHS and the appeal process through the New Jersey Department of Banking and Insurance (DOBI), including instructions on the procedures involved in making such a request. 5. Notification that benefits that the Contractor seeks to reduce, suspend, or terminate will continue while an appeal is pending if the enrollee files an appeal or a request for Fair Hearing (and requests that benefits continue during the Fair Hearing) within the timeframes specified at 4.6.4.C, and that the enrollee may be required to pay the cost of services furnished while the Fair Hearing is pending if the final decision is adverse to the enrollee. 6. A copy of the Grievance Form (based on the approved, DMAHS-issued template). 7. The URL for the online Grievance Form, located on the plan website (as described in Article 5.15.2.E). **5.15.1.A**	**Requires a State-approved policy and procedure addressing grievances and appeals.** ▪ Policies and Procedures addressing the following: ➢ Prior Authorization processes ➢ Enrollee, appeals, and grievances ➢ Provider, appeals, and grievances ▪ Tracking logs ▪ Letters templates ▪ Examples of Provider/Enrollee letters ▪ Member Handbook ▪ Provider Manual		

		DMAHS Approval. The Contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of grievances and appeals by enrollees. The grievance and appeal policies and procedures shall be in accordance with. 42 C.F.R. 438, with the modifications that are incorporated in the contract. The Contractor shall not modify the grievance or appeal procedure without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The Contractor's grievance and appeal procedures shall provide for expeditious resolution of grievances and appeals by Contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management appeals. (For the utilization management appeal process, see Article 4.6.4C.) The Contractor shall review the grievance and appeal procedure at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure. The Contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All enrollees have available the grievance and appeal processes under the Contractor's plan, the Department of Banking and Insurance and, for certain NJ FamilyCare beneficiaries (i.e., Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees), the Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, do not have the right to a Fair Hearing. **6.5.B** Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting. **4.6.4.B.1, 2, 3, 4, 5, 7, 8: See above elements for contract language relating to UM files and appeals.**			
UM16a* Member Grievances – Core Medicaid			▪ File Review	▪	▪
UM16b* Provider Grievance			▪ File Review	▪	▪

– Core Medicaid					
UM16c* Member Appeals – Core Medicaid			▪ File Review	▪	▪
UM16d* Provider Appeals – Core Medicaid			▪ File Review	▪	▪
UM16e* UM – Core Medicaid			▪ File Review	▪	▪
UM16f** Member Grievance – MLTSS			▪ File Review	▪	▪
UM16g** Provider Grievance – MLTSS			▪ File Review	▪	▪
UM16h** Member Appeals – MLTSS			▪ File Review	▪	▪
UM16i** Provider Appeals – MLTSS			▪ File Review	▪	▪
UM16j** UM - MLTSS			▪ File Review	▪	▪
UM17	4.6.4.C	**4.6.4.C** **Appeal Process for UM Determinations** The Contractor shall have policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid	▪ Policies and Procedures Addressing the following: ➢ Prior Authorizations ➢ Addressing Timeliness of Decisions	▪	▪

		Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.	➢ Adverse Determinations ➢ Enrollee and Provider Appeals ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Notice of Action ▪ Member Handbook ▪ Provider Manual		
UM18	B.4.14.XIII.C Appendix	**B.4.14.XIII.C** **Pre-authorization and concurrent review requirements** For organizations with preauthorization or concurrent review programs: 1. The organization implements written policies and procedures, reflecting current standards of medical practice and standards of functionality for long term services and supports, for processing requests for initial authorization of services or requests for continuation of services. a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services. b) Criteria for decisions on coverage, medical and /or functional necessity and service authorization are clearly documented, are based on reasonable medical evidence, or a consensus of relevant health care professionals, or policy guidance by DMAHS and are regularly updated. c) Mechanisms are in place to ensure consistent application of review criteria and comparable decisions on service authorizations are made across reviewers, including Medical Directors. d) A clinical peer, in a same or similar specialty, reviews all decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and /or functional appropriateness. The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services, including MLTSS. The notice specifies the criteria used in denying or limiting	▪ Policies and Procedures addressing the following: ➢ Monitoring the effects of UM program using enrollee and provider satisfaction data ➢ UM program analysis using enrollee and provider satisfaction data ▪ Improvement Plans ▪ Outcome Data	▪	▪

		authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing. e) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. f) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process. g) Mechanisms are in effect to detect both underutilization and overutilization of services. 2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals with appropriate subject matter expertise in the populations and services being authorized. 3. Efforts are made to obtain all necessary information, including pertinent clinical and/or functional information, and consult with the treating provider as appropriate. 4. The reasons for decisions are clearly documented and available to the Member. 5. There are well-publicized and readily available appeals mechanisms for both providers and Members. Notification of a denial includes a description of how to file an appeal. 6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation. 7. There are mechanisms to evaluate the effects of the program using data on Member satisfaction, provider satisfaction or other appropriate measures. 8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.			
UM19*/**	B.9.0 MLTSS Service Dictionary for PDN services. 4.5.3.H N.J.A.C. §10:60-5.4(b)	**B.9.0 MLTSS Service Dictionary** **Private Duty Nursing** Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Prior Authorization ▪ Case Examples	▪	▪

		sources, if medically necessary, and if cost of service provided is less than institutional care. The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services. Service Limitations: Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program. Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care. (a) Private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN). 1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home. 2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle.	▪ Tracking Mechanisms ▪ Member Handbook ▪ Oversight Documentation ▪ Denial Letters ▪ New Jersey Choice Assessment Narrative ▪ Special Care Nursing Facility Level of Care Approval Request		

		(b) Private Duty Nursing shall be a covered service only for those beneficiaries enrolled MLTSS or the DDD Supports Plus program, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty Nursing hours shall supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care. (c) Private Duty Nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.) Approval for private duty nursing service is provided by the Managed Care Organization for MLTSS beneficiaries and DDD Supports Plus PDN enrollees. Approval is provided by the State for Fee For Service beneficiaries. **4.5.3.H** Individuals who are 20 years and older with an intellectual/developmental disability who are identified as receiving Private Duty Nursing shall be referred to the Division of Developmental Disabilities for consideration of the DDD Supports Plus Private Duty Nursing (SPPDN) program. If SPPDN is indicated the MCO shall complete a NJ Choice Assessment when the member is 20.5 years or older and submit to OCCO as assessment type "MCO-Supports Plus PDN" along with the DDD determination. If the member meets Nursing Faculty Level of Care and DDD program requirements the member will be enrolled into the program. A NJ Choice assessment is required annually for all members enrolled in SPPDN program. **N.J.A.C. §10:60-5.4(b)** (b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below: 1. A requirement for all of the following medical interventions: i. dependence on mechanical ventilation; ii. the presence of an active tracheotomy; and iii. the need for deep suctioning; or 2. A requirement for any of the following medical interventions: i. the need for around-the-clock nebulizer treatments, with chest physiotherapy; ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or iii. a seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsants.			

UM20*/**	9.6.5.E 9.6.5.I N.J.A.C. §10:60-5.5(f)3	**Private Duty Nursing Services** **9.6.5.E MLTSS** The Care Manager shall continuously assess/identify a problem or situation and take appropriate action. The Care Manager shall provide more frequent case monitoring when the Care Manager is notified of an urgent/emergent need or change of condition that may require revisions to the existing plan of care. The Care Manager shall conduct a face-to-face visit within twenty-four (24) hours when the situation resulting from the need or change of condition cannot be handled over the telephone or when the Care Manager has reason to believe the Member's well-being is at risk. **9.6.5.I** The Care Manager shall update the written plan of care, in accordance with the Member's assessed needs and goals, at each visit. The Member must indicate his/her agreement with the plan of care each time there is an increase or reduction in services. The Care Manager shall provide the Member a copy of the revised and signed plan of care. **N.J.A.C. §10:60-5.5(f) EPSDT** A nursing reassessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following: 1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services. 2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s). 3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Tracking Mechanisms ▪ Documentation Standards ▪ Care Plans ▪ Oversight Documentation ▪ MLTSS Plan of Care or Service Plans	▪	▪
UM21		**In 2019, this element (UM21) was removed and will no longer be reviewed.**			
UM22*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified,	▪ Narratives and supporting documentation should be filed within each review element as appropriate.	▪	▪

		generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		
Administration and Operations					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
AO1	4.9.3.A 4.9.3.B	**4.9.3.A** The Contractor shall comply with all the provisions of the New Jersey MCO regulations at N.J.A.C. 11.24 et seq. regarding Provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the Members receiving a course of treatment; continuity of care; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and Members who reside in the county in which the hospital is located or in an adjacent county within the Contractor's service area. **4.9.3.B** The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, at least 45 days or as soon as practicable prior to the effective date of suspension, termination, non-renewal of contract, or voluntary withdrawal, or any other form of non-participation of a provider or subcontractor from participation in this program. The Contractor's notice to DMAHS and the MFD shall include the reason for the provider's non-participation in the plan. Failure to report the information required by this section and or failure to report the information in the time period specified will subject the contractor to the provisions of Section 7.36.6 of the Contract. If the termination was "for cause", the Contractor's notice to DMAHS shall include the reasons for the termination. 1. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Member letter of specialist termination in English and Spanish ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination ▪ Notification to providers and enrollees of hospital termination/non-renewal with associated hospital termination/non-renewal date ▪ Notification to DMAHS of terminations ▪ Evidence of notification within 45 days	▪	▪

		2. The Contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date. 3. The Contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.			
AO2	4.9.3.C	**4.9.3.C** If a primary care provider ceases participation in the Contractor's organization, the Contractor shall provide written notice at least thirty (30) days from the date that the Contractor becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice within fifteen days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination	▪	▪
AO3*	5.7.A	**5.7.A** The Contractor shall have in place a Member Services Unit to coordinate and provide services to Medicaid/NJ FamilyCare managed care enrollees. The services include, but are not limited to, enrollee selection, changes, assignment, and/or reassignment of a PCP, explanation of benefits, assistance with filing and resolving inquiries, billing problems, grievances and appeals, referrals, appointment scheduling and cultural and/or linguistic needs. This unit shall also provide orientation to Contractor operations and assistance in accessing care.	▪ Customer Service Departmental Organizational Chart ▪ Customer Service Staff Job Descriptions ▪ Customer Service Department Training Manual ▪ Ongoing Training Materials ▪ Customer Service Desk-Top Procedures ▪ Customer Service Department Orientation schedules ▪ Service Standards ▪ Monitoring reports and documentation showing efforts to address identified deficiencies ▪ Review of Call Center systems	▪	▪

AO4	5.8.5.A 7.24.M	**5.8.5.A** Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information: 1. Name of enrollee 2. Issue date for use in automated care replacement process 3. Primary Care Provider name "or your Medicare PCP" (may be affixed by sticker) 4. Primary Care Provider phone number (may be affixed by sticker) 5. What to do in case of emergency and that no prior authorization is required 6. Relevant co-payments/personal contributions to care 7. Contractor 800 number – emergency message 8. Dental Benefit information. The contractor will provide information on the contractor ID card to assist members with obtaining information for the NJFC dental benefit. If dental services are provided through a subcontractor, both the name of the Contractor and the subcontractor must appear on the card. a. The contractor ID card includes Dental Services as a benefit on the card and a toll free contact number (may be affixed by sticker for existing members) b. For those enrollees that are assigned and change PCD and for new enrollees that are assigned a PCD, a separate ID card from the contractor shall be included in the letter that provides information for the selected or assigned PCD (dentists/dental group). It will include: 1. Name of enrollee 2. Issue Date for use in automated card replacement process 3. Primary Care dentist/office Phone Number 4. Relevant copayments/Personal Contributions to Care 5. Contractor 800 number – indicate types of assistance such as dental benefit questions/assistance 6. Subcontractor 800 number – indicate types of assistance such as assistance in locating a dentist Any additional information shall be approved by DMAHS prior to use on the ID card. **7.24.M** M. The Contractor shall, on a monthly basis, submit a report indicating all undeliverable member identification cards in the format prescribed by DMAHS. The Undeliverable ID Card Report shall be submitted to the State's Health Benefits Coordinator.	▪ Policies and Procedures addressing the following: ➢ Customer Service Department ➢ New Member Process ➢ Post Enrollment ID Card Production ▪ Customer Service Departmental ID Card Production Reports ▪ Monitoring Reports ▪ Example of current ID Card ▪ Example of Dental ID Card for members with PCD	▪	▪
Sub-heading	4.9.6	**4.9.6** **Subcontracts:**			

		In carrying out the terms of the contract, the Contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or administrative services as defined in Article 1. In doing so, the Contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.			
AO5	4.9.6.A - I	**4.9.6.A-I** A. All subcontracts shall be in writing and shall be submitted to DMAHS for prior approval at least 90 days prior to the anticipated implementation date. DMAHS approval shall also be contingent on regulatory agency review and approval. B. The Department shall prior approve all provider contracts and all subcontracts. C. All provider contracts and all subcontracts shall include the terms in Section B.7.2 of the Appendices, Provider/Subcontractor Contract Provisions. D. The Contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the Contractor and the Department. E. Unless otherwise provided by law, Contractor shall not cede or otherwise transfer some or all financial risk of the Contractor to a subcontractor. F. Every third party administrator engaged by the Contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267 G. All Contractors entering into subcontracts with other entities for the provision of health care services should also comply with requirements under 42 CFR 438.3(k), 42 CFR 438.230(a),42 CFR 438.230(b)(1), (2), (3). H. All subcontractors are to comply with requirements in terms of this contract listed in 5.8.2 Enrollee Notification and Handbooks and 6.2 Provider Publications. These documents are to be subject to DMAHS review and approval following the same timelines and requirements as comparable documents produced by contractors. I. Any subcontract where the subcontractor (vendor) provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.	▪ Provider Participation Agreement Template Letter ▪ Administrative Services Agreement between MCO and Service Provider ▪ Copies of agreements or subcontracts with other entities contracted to provide services to MCO enrollee ▪ Contracts between the MCO and subcontractor ▪ QI Program Description ▪ Annual QI Program Evaluation	▪	▪
AO6	7.3.A	**7.3.A** **Staffing**: The Contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The Contractor shall demonstrate to DMAHS' satisfaction that it has the necessary	▪ Organizational Chart ▪ Individual Departmental Organizational Charts	▪	▪

		dedicated, non-delegable New Jersey staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum: 1. A designated administrative liaison for the Medicaid/NJ FamilyCare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative"; See also Article 7.5 below) 2. A full-time Medical Director(s) who shall be licensed as an M.D. or D.O. in New Jersey and meets the experience requirements pursuant to Article 4.6.1(C)(2). 3. A full-time designated position who shall be accountable for: providing leadership in the design, implementation and analysis of the Contractor's strategies and approaches to prioritize and address health equity, including by supporting organizational health equity goals through identifying, analyzing, and addressing health disparities, advising and participating in performance improvement plans and interventions related to health disparities, cultural competence training, modifying and establishing internal and external policies and procedures to address and incorporate health equity, and reporting on organizational diversity activities to advance equity and facilitate an inclusive workforce to support Enrollees. 4. A full-time senior executive dedicated to MLTSS who has at least five (5) years of experience administering managed long term care programs. Equivalent experience administering long term care programs and services, including HCBS, or in managed care may be substituted, subject to DMAHS approval. 5. A Dental Director - who shall be licensed as a DDS or DMD in New Jersey 6. Behavioral Health a. A full time behavioral health administrator who is a New Jersey licensed social worker (LSW), licensed registered nurse (RN), clinical nurse specialist (CNS), licensed advanced practice nurse (APN), physician or psychologist with experience serving chronically ill populations with mental health and Substance Use Disorders, at least three (3) years of experience serving in a managerial/leadership role and knowledge of managed care. This individual shall be responsible for developing, implementing, and coordinating behavioral health services and settings that can meet the needs of Members with behavioral health needs. b. A Behavioral Health Medical Director who is a board-certified psychiatrist licensed in the State of New Jersey. The Behavioral Health Medical Director shall also have significant clinical experience in the treatment of substance use disorders, including utilization of ASAM criteria, and an understanding of the New Jersey system of care. Subspecialty board certification can be by the American Board of Psychiatry and Neurology (ABPN), the American Osteopathic Association (AOA), or the American Board of Preventive Medicine (ABPN). The BH Medical Director must possess at least five years combined experience in mental health and substance use services and at least two (2) years of BH leadership experience in a government, health management, or managed care organization, and/or at least two (2) years of experience as a Medical	▪ Key staff job descriptions listing essential duties and responsibilities, education, experience, required qualifications, licensure and/or certification for the position		

		Director in clinical practice, and/or at least three (3) years of clinical BH experience (excluding psychiatric residency). The BH Medical Director must be employed directly by the Contractor and not subcontracted. This individual shall be responsible for leadership and counsel for utilization management and case management programs for mental health and substance use disorder services and collaboration with DMAHS, and other state agencies, to oversee the implementation of BH integration efforts. The responsibilities of the Behavioral Health Medical Director include: i. Participation in the development of clinical practice standards, policies, and procedures, ii. Responsibility for behavioral health care management performance and coordination with physical health care management, iii. Participation in DMAHS and other agency/stakeholder meetings when requested, iv. Oversight and implementation of the utilization management program for behavioral health services, including preventing contraindicated care, v. Ensuring consistency in the application of utilization management standards, including those implemented by subcontracted entities, vi. Overseeing the complaint and grievance process for behavioral health denials, vii. Review and resolution of quality of care concerns, and viii. Participation in clinical staff recruitment and ongoing performance improvement. ix. Oversee behavioral health administrator role and functions. c. A full-time Behavioral Health Care Management Supervisor who is a New Jersey licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed advanced practice nurse (APN), physician, or psychologist with experience serving chronically ill populations with mental health and/or Substance Use Disorders, at least two (2) years of care management experience, at least three (3) years of experience serving in a managerial/leadership role, and knowledge of managed care. The behavioral health care management supervisor shall be responsible for the overall day to day administrative and clinical supervision of the behavioral health care management unit. Their responsibilities shall include: i. Monitoring treatment plans to ensure integration of care, ii. Promoting cost-effective treatment planning, iii. Supporting coordination of care across contractor units and community providers. iv. Developing strategies to improve outcomes d. A full-time Behavioral Health Director of Network Relations. The Director of Network Relations must have an office located in New Jersey that they are able to utilize on a regular basis and shall have at least five (5) years of experience in managed care network management. The primary functions of the Director of Network Relations are:			

		i. Involvement in the development and maintenance of a credentialed Provider network that is geographically proportionate for provider specialties, ii. Meet provider services requirements under this Agreement; iii. Provide provider education and develop and deliver provider training; iv. Ensure network adequacy and appointment access, including development of network resources for identified unmet needs; this includes single case agreements, recruiting providers to meet unmet service capacity; v. Ensure that contracted providers impacted by population health initiatives, such as quality improvement projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers; vi. Collaborate with other managed care entities to simplify provider requirements and remove administrative barriers across credentialing health plans and; vii. Develop and implement provider claim dispute resolution process. viii. Conduct access and availability rounds with care managers e. A Behavioral Health Quality Management Supervisor that may report to the existing QM Director. The Supervisor shall be either, a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Healthcare Quality, or be Certified in Healthcare Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The Supervisor shall have at least three (3) years of experience in quality management and quality improvement. Key responsibilities shall include: i. Ensuring that systems and procedures exist that assess provider satisfaction. Assessment shall include provider experiences with claims processing, prior authorization, utilization management, and provider complaint resolution, ii. Implementation of quality measures of network adequacy, iii. Implementation of processes designed to improve access to care for special needs populations including, but not limited to, physically handicapped individuals, individuals with co-occurring conditions, victims of sexual abuse, deaf or blind individuals, pregnant people, and individuals with developmental delays, iv. Resolving, tracking, and trending quality of care complaints, v. Ensuring the contractor or its behavioral health subcontractor comply with quality management requirements included in this agreement, and vi. Ensuring the network is capable of providing services to a culturally and ethnically diverse population with attention to disparities in access or outcomes experienced by traditionally marginalized populations. f. Behavioral Health Care Managers shall have a minimum of a Bachelor's degree in psychology, social sciences, social work, nursing, or a related field, at least two (2) years of work experience in public health or related field, and at least two (2)			

		years of care management experience serving chronically ill populations with mental health and/or substance use disorders. Certified case managers (CCM) are preferred. 7. Financial officer(s) or accounting and budgeting officer 8. QM/UR coordinator who is a New Jersey-licensed registered nurse or physician 9. Prior authorization staff sufficient to authorize medical, behavioral, dental and MLTSS services twenty-four (24) hours per day/seven (7) days per week 10. A full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years of experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff 11. A designated Care Manager or supervisor to act as administrative liaison between the Contractor and the various State entities for the MLTSS Care Management requirements set forth in this contract. At a minimum, this individual shall meet the Care Manager requirements pursuant to Article 9.5.2 and have a minimum of four (4) years experience serving enrollees receiving long term services and supports 12. Designated Medicaid Care Manager(s) who shall be available to DMAHS medical staff to respond to medical, behavioral or MLTSS related problems, grievances, and emergent or urgent situations 13. Member services unit head 14. Provider services unit head as well as a provider services liaison dedicated to MLTSS. The Contractor shall identify one or more MLTSS provider representatives for MLTSS providers. MLTSS provider representative(s) shall be responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing and other MLTSS provider needs. The MLTSS provider representatives shall conduct ongoing communications with MLTSS providers through provider forums, webinars, dedicated toll-free MLTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes 15. Encounter reporting staff/claims processors supervisors 16. Grievance coordinator 17. A full-time designated MLTSS Member Representative responsible for internal representation of the interests of MLTSS Members including but not limited to input into planning and delivery of long term services and supports, participation in QM/QI activities, assistance with program monitoring and evaluation, and provision of education to enrollees, families, and providers on issues related to the MLTSS program. The MLTSS Member Representative shall assist MLTSS Members in navigating the Contractor's system. This shall include, but not be limited to, helping MLTSS Members understand and use the Contractor's system, being a resource for MLTSS Members, providing information, making referrals to appropriate Contractor staff Members, and facilitating resolution of any issues. The MLTSS Member			

		Representative shall make recommendations to the Contractor on any changes needed to improve the Contractor's system for MLTSS Members, and participate as an ex officio Member of the Contractor's Consumer Advisory Committee. 18. A Nursing Facility Transition/Money Follows the Person program staff person possessing the skill and knowledge to assist in coordinating and facilitating Member transition from nursing facilities to the community. 19. A fulltime, dedicated Self-Direction Program Director who is knowledgeable in all aspects of participant direction operations and service delivery including, but not limited to: enrollment, eligibility, fiscal intermediary operations, claims payment, member communications, Electronic Visit Verification, program integrity, and coordination of services for all enrollees. This person will serve as the liaison between the MCO, VF/EA, the Member, and the State. 20. Adequate administrative and support staff 21. Compliance Officer 22. Housing Specialists who shall directly assist Members enrolled in Housing Supports, MLTSS, and those participating in Healthy Homes to identify, secure, and maintain community-based housing and act as a liaison to DMAHS staff, or its designee, to receive training and capacity building assistance and to submit required reports. Housing Specialist(s) must be dedicated, full-time staff persons whose primary responsibility is housing-related work. This shall not be staff to whom housing-related work has been added to their existing responsibilities and function within the MCO. a. Housing Specialist(s) shall have at least three (3) years' full-time experience in assisting vulnerable populations (e.g. homeless, elderly, people with disabilities, etc.) to secure accessible, affordable housing. The Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources. b. The Contractor shall provide evidence of the aforementioned qualifications for those individuals or entities hired/designated as Housing Specialist(s) and/or Housing Intake Coordinator(s) upon request of DMAHS. ▪ c. The Contractor shall adequately hire housing specialists as defined in Housing Supports Guidance. ▪ d. At least one, and more if needed, Housing Specialist(s) will be designated as the Nursing Home Transition Housing Specialist and shall assist Members residing in nursing homes who wish to return to the community to identify, secure and maintain community-based housing. The Contractor must report on how many FTEs they have designated as the Nursing Home Transition Housing Specialist(s); these FTEs may not also be assigned a Housing Supports program caseload.			

		23. Housing Services Manager, or an equivalent position, must be a full-time manager-level position providing oversight of all housing specialists while also acting as the Contractor's central housing expert(s) to provide housing education and assistance to housing specialists, care management staff, and other Contractor staff. ▪ a. Contractor's housing services managers should have at least two (2) years of experience as a housing specialist, or have both a bachelor's degree in social work or similar degree (e.g., psychology, social sciences, nursing) and at least three (3) years of experience assisting vulnerable populations to secure accessible, affordable housing and must be familiar with relevant public and private housing resources and stakeholders. ▪ b. The Contractor shall adequately hire housing services managers as defined in the Housing Supports Guidance. 24. A Housing Services Director, or an equivalent position will be a full-time manager-level position providing oversight of all housing-related services and Contractor housing staff and must be hired prior to April 1, 2024. The Director must be dedicated to the Contractor's New Jersey program only and will be responsible for ensuring coordination of Housing Services with all other services provided to Members by the Contractor. The Director will be responsible for creating an integrated housing strategy as well as housing related policies and procedures and cultivating stakeholder relationship. The Director will coordinate Housing Services Manager's and Housing Specialists' duties. The Director will ensure that the Contractor has the structure and systems in place to ensure successful provision of services to Members in the Housing Supports, Healthy Homes, or MLTSS programs or transitioning to the community for a nursing facility. 25. NJ Dedicated Pharmacy Director.			
AO7	7.3.C 7.3.D	**7.3.C** **Training** The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. **7.3.D** The Contractor shall ensure compliance with all mandated training programs as required by DMAHS. The Contractor shall comply with Articles 5.14, 9.5.3 and 9.5.4 regarding MLTSS staff training.	▪ Policies and Procedures addressing the following: ➢ Staff Selection and Placement, Retention, and Background Checks ➢ Examples of Website Training Programs Screen Print ➢ General Orientation Materials ➢ Departmental Orientation Documents	▪	▪

			➢ Ongoing Training Documents ➢ Resumes/Bios ➢ Job Descriptions		
Sub-heading	B.4.14.VIII Appendix	**B.4.14.VIII** **Delegation of QAPI Activities** The MCO remains accountable for health services management and all QAPI functions, including those pertaining to MLTSS even if certain functions are delegated to other entities.			
AO8	B.4.14.VIII.B Appendix	**B.4.14.VIII.B** The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care provided.	▪ Policies and Procedures addressing the following: ➢ Monitoring and Evaluating Delegated Activities ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Evidence of monitoring activities	▪	▪
AO9	B.4.14.VIII.C Appendix	**B.4.14.VIII.C** There is evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.	▪ Delegation Oversight Audits and findings including any corrective action ▪ Entire Year of the most recent committee oversight meeting minutes such as Credentialing Committee and Medical Management	▪	▪
AO10	B.4.14.VIII.D Appendix	**B.4.14.VIII.D** The organization evaluates the entity's ability to perform the delegated activities prior to delegation.	▪ Policies and Procedures addressing the following: ➢ Evaluation Prior to Delegation ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Pre-Delegation Evaluation Audit findings	▪	▪

AO11	B.4.14.VIII.E Appendix	**B.4.14.VIII.E** If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.	▪ Quality Improvement Program Description ▪ Credentialing Program ▪ Policies and Procedures addressing the following: ▪ Delegation Agreement Process and Structure ▪ Credentialing Delegation – Scope of Work and Performance Standards ▪ Credentialing Committee Charter ▪ Delegation Agreements ▪ Entire Year of the most recent Credentialing Committee Meeting Minutes	▪	▪
AO12**	4.8.1.M 4.9.2.E	**4.8.1.M** M. **MLTSS Any Willing Provider and Any Willing Plan.** The definition of MLTSS Any Willing Provider refers to any New Jersey-based assisted living provider (AL)or community residential services (CRS) provider that serves residents with traumatic brain injury. The definition also applies to long-term care pharmacies that apply to become network providers. These Medicaid Providers must comply with the Contractor's provider network participation requirements and are included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based assisted living provider (AL) or community residential services provider (CRS) join its network, those providers will be instructed to complete the application form which is known as Any Willing Plan. The Contractor must accept all ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers. Network participation of these provider types cannot be denied based on the application of a subjective standard. 1. MLTSS Any Willing Provider status for AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2025, dependent upon available appropriations and except as defined by the Commissioner and upon appropriate notice to the Contractor. For AL and CRS that would mean that Any Willing Provider status expires on June 30, 2025, except as defined by the Commissioner and upon appropriate notice to the Contractor. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. Any provider found not to be in compliance with the federal Home and Community Based Settings Rule as detailed in	▪ Evidence of compliance with AWP requirements – procedures relating to contracting for NFs, SCNFs, ALs and CRSs; ▪ Contracts executed to serve MLTSS population ▪ Correspondence with providers requesting participation	▪	▪

		Article 9.8 after a good faith effort by the MCO to assist the provider with becoming compliant shall be exempted from Any Willing Provider status. A provider found to be non-compliant is subject to removal from the MCO provider network. 2. The rates for AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, performance on specified quality metrics, or other factors dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers. 3. The Any Willing Plan status also expires June 30, 2025. **4.9.2.E** **Contract Submission**: MLTSS provider contracts and subcontracts – The Contractor shall include the MLTSS Any Willing Provider (AWP), Any Willing Qualified Provider (AWQP), and contract term period provisions as necessary and as detailed at 4.8.1M. The Contractor shall contract with all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0) and include all required provider specification requirements. These include, but are not necessarily limited to: 1. Nursing Facility - The Contractor shall include in Custodial and Rehabilitation facility contracts, a notice requirement for the facility/provider to contact the Contractor prior to or within 24 hours of admission for authorization of care. 2. Assisted Living Services (ALR, CPCH) – Assisted Living Facility a. Assisted Living Residences (ALR) b. Comprehensive Personal Care Home (CPCH) 3. Assisted Living Program (ALP) 4. TBI Behavioral Management (Group and Individual) 5. Caregiver/Participant Training 6. Cognitive Therapy (Group and Individual) 7. Community Residential Services (CRS) 8. Medical Day Services 9. MLTSS PCA a. The Contractor shall, in any Provider contract for personal care services, require that the increase in hourly rate above the hourly rate paid in state fiscal year 2018 be used solely to increase payments to workers who directly provide personal care services consistent with P.L. 2017, c. 239 1. b. The Contractor shall, in any Provider contract for personal care services, inform the Provider that it will be required to report to DMAHS showing compliance with the requirement to increase payments to direct care workers consistent with P.L. 2017, c. 239 2.			

		10. Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy (Group and Individual) 11. Private Duty Nursing (Adult) 12. Specialized Medical Equipment and Supplies and Evaluation 13. Supported Day Services 14. Non-Traditional Provider Contracts –All model contract forms with Non-Traditional providers shall be submitted on a file and use basis thirty (30) days prior to the effective date, and shall comply with all applicable State and federal laws. Services may include: Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, Medication Dispensing Devices and Monthly Monitoring, Non-Medical Transportation; Personal Emergency Response System (PERS) Device, Set Up, and Monitoring, Residential and Vehicle Modifications, Respite, Social Adult Day Care, Structured Day Program.			
AO13*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.	▪	▪
AO14*	4.7.2.A.11	**4.7.2.A.11** **Report of Accreditation Status** a. Contractor is required to attain NCQA's Health Plan Accreditation and the Health Equity Accreditation by July 1, 2026, and maintain the status throughout the duration of the contract. b. Contractor is required to inform the State, at least annually and upon any change of accreditation, whether it has been accredited by a private independent accrediting entity. c. Contractors that have received accreditation by any private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including: i. Accreditation entity name ii. Accreditation status, survey type, and level (as applicable)	▪ Evidence of annual notification to DMAHS of accreditation status, or more frequently if there are any changes in accreditation.	▪	▪

		iii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings, and iv. Expiration date of the accreditation. d. Contractors must make the accreditation status available on their Web sites to include: i. Whether the Contractor has been accredited by a private independent accrediting entity ii. the name of the accrediting entity, accreditation program, and accreditation level (as applicable) iii. Update this information annually or more frequently if that are any changes in accreditation.			
Management Information Systems					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Review Comments**
Sub-heading	3.1.2.A	**3.1.2.A** **Timely Processing** The Contractor shall provide for timely updates and edits for all transactions on a schedule that allows the Contractor to meet the State's performance requirements. At a minimum, this shall include the following:			
IS1	3.1.2.A.1	**3.1.2.A.1** Enrollee and provider file updates to be daily;	▪ Sample Reports ▪ Daily Updated Enrollee Files Report ▪ Policies and Procedures addressing the following: ➢ Frequency of Enrollee and Provider File Updates	▪	▪
IS2	3.1.2.A.2	**3.1.2.A.2** Reference file updates to be at least weekly or as needed;	▪ Sample Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Reference File Updates	▪	▪
IS3	3.1.2.A.3	**3.1.2.A.3** Prior authorizations and referral updates to be daily;	▪ Sample Pre-Service Request Turn-around Time Reports ▪ Sample Pre-Service Request Reports	▪	▪

			▪ Policies and Procedures addressing the following: ➢ Frequency of Prior Authorization and Referral Updates		
IS4	3.1.2.A.4	**3.1.2.A.4** Claims and encounters to be processed (entered and edited) daily;	▪ Paid, Incurred, and Pended Claims Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Claims and Encounters Processing	▪	▪
IS5	3.1.2.A.5	**3.1.2.A.5** Claim payments to be at a minimum biweekly except as necessary to meet the requirements in Article 7.16.5	▪ Example of Provider Remittance Inventory with receipt date ▪ Policies and Procedures addressing the following: ➢ Claims Processing	▪	▪
IS6	3.1.2.A.6	**3.1.2.A.6** Capitation payments to be monthly	▪ Policies and Procedures addressing the following: ➢ Capitation Payment Processing ➢ Check Register Lists	▪	▪
IS7	3.1.3.A	**3.1.3.A** **Regular Reporting** The Contractor's system shall provide sufficient reports to meet the requirements of this contract as well as to support the efficient and effective operation of its business functions. The required reports, including time frames and format requirements, are in Section A of the Appendices.	▪ Master Report Schedule ▪ Compliance Tracking Documents	▪	▪
IS8	3.1.3.B	**3.1.3.B** **Ad Hoc Reporting** The Contractor shall have the capability to support ad hoc reporting requests, at no additional cost, in addition to those listed in this contract, both from its own organization and from the State in a reasonable time frame. The time frame for submission of the report will be determined by DMAHS with input from the Contractor based on the nature of the report. DMAHS shall at its option request six (6) to eight (8) reports per year, hardcopy or electronic reports and/or file extracts. This does not preclude or prevent DMAHS from requiring, or the Contractor from providing, additional reports, at no additional cost, that are required by State or federal governmental entities or any court of competent jurisdiction.	▪ Information System (IS) Data Reporting Request Form ▪ Sample of Ad Hoc Reports ▪ IS Vendor Request Form ▪ Provider Data Reporting Request Form	▪	▪
IS9	3.7.1.A	**3.7.1.A**	▪ Sample Performance Reports	▪	▪

	3.7.1.A.3	The system shall provide data to assist in the definition and establishment of Contractor performance measurement standards, norms and service criteria. **3.7.1.A.3** It should maintain data for medical, behavioral, dental and MLTSS assessments and evaluations.	▪ HEDIS® Reports ▪ MLTSS assessment and evaluation reports		
IS10	3.7.1.A.7	**3.7.1.A.7** Reports should facilitate at a minimum monthly tracking and trending of enrollee care issues to monitor and assess Contractor and provider performance and services provided to enrollees.	▪ Policies and Procedures addressing the following: ➢ Tracking and Trending ➢ Monthly Tracking Reports such as: ➢ Quality of Care/Service ➢ Grievances ➢ Utilization of Services ➢ Access and Availability	▪	▪
IS11	3.8	**3.8** The MCMIS shall have a comprehensive reporting capability to support the reporting requirements of this contract and the management needs for all of the Contractor operations.	▪ Grievance Reports ▪ Pended Claims Reports ▪ Quality Reports ▪ Sample of canned reports such as: ▪ Member grievance report ▪ Monthly dashboard reports ▪ Monthly pended claims report	▪	▪
IS12	3.8.1.D	**3.8.1.D** The Contractor shall acquire the capability to receive and transmit data in a secure manner electronically to and from the State's data centers, which are operated by OIT. The standard data transfer software that OIT utilizes for electronic data exchange is Connect: Direct. Both mainframe and PC versions are available. A dedicated line is preferred, but at a minimum connectivity software can be used for the connection.	▪ Flowchart of Network Process ▪ Data Transfer Procedure ▪ A Screen Print of Logins ▪ Confirmation correspondence from DMAHS showing receipt of electronically submitted data	▪	▪
IS13	3.1.2.F	**3.1.2.F** If the Contractor uses different systems or engages in a delegated or sub-contracting arrangement for physical health, behavioral health and/or long-term services and supports, these systems shall be interoperable with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.	▪ Flowchart showing integration of data from delegated entities ▪ Demonstration of plan access to delegated services	▪	▪

IS14***	3.1.2.G	**3.1.2.G** The Contractor shall ensure that images of documents used by Members and providers to support Care Management processes are indexed and maintain logical relationships to certain key data such as Member identification and provider identification number.	▪ Demonstration of document management for MLTSS ▪ Review of MLTSS CM system	▪	▪
IS15**	3.1.2.I	**3.1.2.I** The Contractor's system shall be able to electronically track, store and share real-time the end- to-end data necessary to complete MLTSS Care Management processes for enrollees receiving long term services and supports including but not limited to, systems alerts for changes related to identification of potential members and the referral date of MLTSS clinical eligibility evaluation, MLTSS status, financial data, clinical eligibility status, NJ Choice assessment system assessment data, and plan of care data. See Article 9.2 for additional detail on the Member's electronic Care Management record.	▪ System documentation regarding tracking of alerts ▪ Integration of new enrollees in MLTSS system ▪ Reporting of potential MLTSS members ▪ Review of MLTSS system onsite	▪	▪
IS16	3.1.2.J	**3.1.2.J** The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level. If the Contractor's integrated systems include other lines of business, (e.g. Medicare or commercial insurance, or Fully Integrated Dual Eligible (FIDE) SNP) or business in other states, those systems must have the capability to segregate the information by state and product line to allow for direct viewing of all Medicaid/NJ FamilyCare information by the State and/or its vendors.	▪ Documentation relating to capability of separating NJ specific LOBs ▪ Demonstration of electronic access to NJ CM, UM, Claims, Grievances for NJ DMAHS staff and their representatives ▪ Security documents/policies related to access to NJ LOB data	▪	▪
IS17**	3.1.2.K	**3.1.2.K** The Contractor's system shall include a means for the MLTSS Care Manager to ensure that home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary. This shall include either notification from providers or Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.	▪ Reports of services rendered to MLTSS members ▪ Flowchart on MLTSS reporting ▪ Demonstration of real time access to service data	▪	▪
IS18*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion.	▪	▪

			▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		

2025 Core Medicaid Care Management Document Submission Guide

Appendix H2

January 2024 and July 2024 (Amendment) NJ FamilyCare Managed Care Contracts utilized for this review

Care Management and Continuity of Care					
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**	**Met/Not Met**	**Reviewer Comments**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of, or having special needs who should be referred for a Comprehensive Needs Assessment. (See Care Management Workbook at https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for information on Comprehensive Needs Assessment). This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** In addition to the standards set forth in this Article, the Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits		

CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description		
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Care Management Standards. Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:			
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following:		

		slowing the deterioration of their health status.	➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs		
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan		
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care		

		by multiple providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.	➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team		
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:			
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), with ongoing care coordination and management as	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts		

		appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Unable to Reach Process ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees		
CM7	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees, following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees and any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Unable to Reach Process ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results		
CM8	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description		

		Plan should be culturally appropriate and consistent with the abilities and desires of the Member and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation		
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs and level of care. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance		
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description		

		develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals		
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans		
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The MCO Care Management Program Policy and Procedure submitted to DMAHS annually must include protocols detailing how it collects and monitors population-based outcomes. The MCO will conduct satisfaction surveys using the DMAHS approved Care Management Member Experience Survey tool. The Survey results will be made available to DMAHS upon request and/or to the EQRO during the Annual Care Management Audit and Assessment.	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement ➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies		

CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies		
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation		
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description		

CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description		
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports		
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description		

		services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.			
CM18c	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy		
CM18d	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details.	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy		
CM19	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports ▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes		

CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook		
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team		
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters		
Sub-heading	4.6.5. I	**4.6.5.I** Level of Service			

CM23	4.6.5.I.2 4.6.5. L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change. **4.6.5.L** Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies		
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies		
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual		
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description		

		normal office hours, Monday through Friday.	➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement		
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities ➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description		

		an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.			
CM37	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.		

New Jersey Annual Assessment of MCO Operations
Appendix H3

MLTSS HCBS CM
2025 MLTSS CM Audit Submission Guide

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.6 4.1.1.F.1 9.3.3 9.3.3.A 9.3.3.B 9.3.3.C 9.3.3.D 9.3.3.E 9.3.3.F 9.6.6.E 4.1.1.E 9.6.6.F	4.6.5.D.6 If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty-five (45) calendar days of the Enrollee's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. The new Contractor shall follow the Care Management process outlined in Article 9.6. If a Member resides in a NF, SCNF or community alternative residential setting, the new Contractor shall continue to provide services to the Member in accordance with the level of services approved by the relinquishing Contractor; however, after participating in options counseling the Member may elect to be transitioned to a more integrated community setting, if appropriate.	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		9.3.3 The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: 9.3.3.A Have a mechanism for allowing a Member to request and be granted a change of provider; 9.3.3.B Notify providers of their role in providing continuity of care for their members in transition; 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services to include NF/SCNF to NF/SCNF Transfer(s); 1.Care Manager shall make telephonic contact with the receiving facility within five (5) business days of placement following a member's transfer, 2.Care Manager shall complete a Face-to-Face visit and update the member's plan of care within forty-five (45) business days of placement. 9.3.3.D Work with the provider that is no longer willing or able to provide services to a Member to cooperate with the Member's Care Manager to facilitate a seamless transition to another provider and continue to provide services to the Member until the Member has been transitioned to the other provider; 9.3.3.E	

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		Have a mechanism for information exchange between providers in accordance with termination timeframes outlined in section 4.9.3; and 9.3.3.F. Have a mechanism for ensuring confidentiality as specified in Article 7.38. 9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Enrollees the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. New enrollees who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General MLTSS Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-neutral manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1.D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long-term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS A. General Requirements 1. The electronic Member record shall be complete, comprehensive and confidentially maintained in accordance with section 9.2.2B. 2. The Contractor shall maintain the integrity of the electronic Care Management member record documentation and shall ensure the availability of the record through electronic submission and in hard copy. When printed, the Contractor shall ensure each case file page indicates the Member's name and unique identifier; each entry made shall be dated and shall identify the specific Care Manager. 3. The Contractor shall maintain a uniform tracking system for documenting the beginning and end dates and number of units of all	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health, and long-term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		authorized services, as applicable, in each Member's electronic Care Management record.	
CM30	9.5.1.I 9.5.1. J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers, and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers, and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2. B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members; 2. Caseload management and casework practices; 3. Human services principles for determining eligibility for benefits and services;	▪ MLTSS Care Management job descriptions used in recruitment. ▪ Organization Chart with CM names ▪ MLTSS CM Staff Qualifications ▪ CM resumes

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A Training of Care Management Staff A. The Contractor shall develop standardized initial and ongoing quarterly and annual training and education which includes the following components: 1.Training curriculum including topic, goals of training, length, format, materials, prerequisites, and competency standards for each training area 2.Training records for each employee documenting trainings completed, date, competency and remediation actions 3.Quality Assurance program to identify inter/intra-rater reliability and core standards 4.Continuous Quality Assurance monitoring and standards to ensure standards are being met 5.Remediation training plan for employees who do not meet the standards 9.5.4.A A. Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request. 9.5.4.B All MLTSS Care Managers must be NJ Choice certified and able to conduct the NJ Choice Assessment System for initial and re-evaluations.	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		The Contractor shall submit to DoAS a complete listing of Care Management Training and Education activities scheduled for each calendar month. Reports are due by the 20th day of the month prior to the scheduled training month. The listing shall include the training title, description, instructor, date and time, target audience, and location or mode of delivery.	
CM34	9.5.5. K	9.5.5.K Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2. A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4. A	4.7.4. A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Care Management and Continuity of Care			
2025 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM38	9.4.1.A.4 9.5.1. E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. MLTSS members shall have no more than one change in their assigned primary Care Manager within a calendar year unless the change is due to member relocation, change in Care Manager employment (i.e. termination or leave), requested by member, or any other reason approved by DMAHS. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy