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

CORE MEDICAID and MLTSS QUALITY TECHNICAL REPORT

January 2018–December 2018

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EXECUTIVE SUMMARY

Background

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

The MCOs Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and WellCare Health Plans of New Jersey, Inc. (WCHP) participated in the NJ FamilyCare Managed Care Program in 2018. Enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long Term Services and Supports (MLTSS) was 1,626,991 as of 12/31/2018.

External quality review (EQR) activities conducted during January 2018–December 2018 included annual assessment of MCO operations, performance measure (PM) validation, performance improvement projects (PIPs), DMAHS encounter data validation, a focused quality study, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, Core Medicaid care management (CM) audits, and MLTSS CM Audits.

State Initiatives

The information for the state initiatives is provided in its entirety by DMAHS and included verbatim herein.

The New Jersey Medicaid Accountable Care Demonstration Project

In August 2011, Governor Christie signed into law (NJ P.L. 2011, Chap 114) requiring DMAHS to establish a three year Medicaid Accountable Care Organization (ACO) Demonstration project designed to improve health outcomes, quality and access to care through regional collaboration, and shared accountability while reducing costs. The NJ Medicaid ACO Demonstration provides Medicaid an opportunity to explore innovative system re-design, including: testing the ACO as an alternative to managed care; rethinking how care management and care coordination should be delivered to high risk, high cost utilizers; stretching the role of Medicaid beyond just medical services but to integrate social services as well; and finally, testing payment reform in terms of pay for performance metrics and incentives. DMAHS launched the Demonstration in July 2015, which was to conclude in June 2018, but the Demonstration was extended for one year for transitional purposes. A baseline report from year one of the Demonstration has been published. Reports from both year two and three are anticipated to be published in 2019.

Health Information Technology

DMAHS recognizes the critical role of health information technology (HIT) as a transformation enabler. Current challenges in health system integration arising from information silos have impeded care coordination and resulted in duplication of services, medical errors, and administrative inefficiencies. The Medicaid Management Information System (MMIS) is an important component of program operations that is vital to advancing the goals of DMAHS and other agencies that comprise the Medicaid enterprise to provide services that are cost-effective and result in high quality outcomes.

In February 2015, DMAHS awarded the contract for the Replacement MMIS to Molina Medicaid Solutions, now DXC Technology. The Design, Development, and Implementation phase began in mid-2015, with a planned late 2019 implementation timeline. Currently, Phase 3 (Requirements Analysis and Design) of the System Development Life Cycle is nearing completion, and tasks and activities for Phase 4 (Development and Test) and Phase 5 (Implementation and Readiness) have already begun. Multiple phases run concurrently in this agile deployment. The goal of the project is to provide DMAHS with the system infrastructure, technical capabilities, and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation.

The new system, referred to as the Replacement MMIS, will help ensure that members receive quality, coordinated, and person-centered health services, that programs are effectively administered with the help of decision support tools, and that fraud, waste, and abuse are prevented, detected, and addressed. The Replacement MMIS will enable NJ to achieve program goals that are critically intertwined with health information technology and electronic exchange of data to improve health outcomes and control program costs.

DMAHS aims to implement an agile information system that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the Replacement MMIS will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system.

Medicaid Information Technology Architecture Project and Master Client Index Project

In addition to the Replacement MMIS project DMAHS established an Enterprise Master Client Index (MCI) in May 2015, linking the NJ Medicaid Management Information Systems (MMIS) with the NJ Department of Health (DOH) Blood Lead Registry and the DOH Immunization Registry. The MCI will be integrated with the new Replacement MMIS project for MMIS identity management and to meet RMMIS bi-directional data exchange requirements with NJ State Health Registries. The MCI is a Master Data Management (MDM) project providing identity management necessary to link client data that resides in disparate system databases for the same person where the patient demographics lack 100% consistency with regard to format and content. The MCI is used to cross reference client identifiers across each participating information system to uniquely identify each client, perform global searches and matching, consolidate duplicate client records, and create complete views of client information and share data easily across multiple facilities and information systems.

Medicaid Innovation Accelerator Program

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

Community Based Care Management Demonstration

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

The MCOs were provided a template by DMAHS from which to design programs that would provide community based care management for 10% of their non-MLTSS members whose high needs require intensive, in-person interventions to assure that the selected members are making progress with their care plans. The new programs were implemented beginning January 1, 2016. DMAHS is currently in its second year of tracking and trending outcomes to determine the program's effectiveness. Community Based Care Management is intended to enhance the Plans' existing Care Management programs that were implemented in 2012.

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

NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), the Human Services Research Institute (HSRI), state Medicaid, and aging and disability agencies. New Jersey voluntarily participates in this extensive, confidential, face to face consumer survey which focuses on people with physical disabilities and on older adults. The purpose of the survey is to procure feedback directly from service recipients

regarding service satisfaction and quality of life issues. The NCI-AD survey is important to NJ because data gleaned from survey participants can be measured, tracked, and applied to future State initiatives. The MACCs (Medical Assistance Customers Centers), MLTSS Steering Committee, PACE (Program of All-Inclusive Care for the Elderly), NJ Hospital Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey, as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy. New Jersey first partnered with NCI-AD in 2015 and surveyed over seven hundred people. In 2017-2018, over 800 residents were surveyed, including MLTSS members, both in the community and in NFs, and PACE members. Participants in the survey were individuals who have been receiving long term services and supports for a minimum of six months. Recipients were assessed regarding the outcomes of services they received with the goal of assisting the State to improve the quality of services and supports that are provided to NJ residents. Surveyors received annual training regarding the survey process inclusive of creating a positive survey experience, interview techniques for older adults and people with disabilities, the use of proxy assistance, and mandatory reporting requirements. The 2017-2018 survey contained approximately ninety questions that included the domains of: home, relationships, service satisfaction, direct care workers, daily activities, physical environment, safety/security/privacy, community, everyday living, health and wellness, healthcare, future planning, and independence. New Jersey also created twelve questions unique to the State that addressed specific concerns relevant to NJ and its residents. These included the categories of member needs, in-home assistance, home delivered meals, and individualized plans of care. At the end of the survey interviewers provide feedback and any unmet needs that the individual identified and wished to have addressed were noted and appropriate follow-up was performed. As participating states measure and track their own performance, NJ State-specific performance reports regarding core indicators are available for year over year comparison, along with additional information regarding the NCI-AD survey process, on the NCI-AD website, www.nci-ad.org.

Annual Assessment of MCO Operations

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

2018 Annual Assessment of MCO Operations

For the review period 7/1/2017–6/30/2018, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2018 compliance scores from the annual assessment ranged from 91% to 97%. HNJH's compliance score increased 6 percentage points from 91% to 97% in 2018. ABHNJ's compliance score increased from 87% to 91% in 2018. Access, Care Management and Continuity of Care, and Utilization Management had one previous element split into 4, 7, and 11 elements, respectively, and hence the compliance scores for these standards cannot be directly compared to those in 2017. One standard (Credentialing and Recredentialing) decreased 2 percentage points from an average compliance score of 96% in 2017 to 94% in 2018. Average compliance for three standards (Committee Structure, Provider Training and Performance, and Enrollee Rights and Responsibilities) remained the same from 2017 to 2018. Average compliance for the remaining seven standards showed slight increases ranging from 2 percentage point increases each for Quality Assessment and Performance Improvement, and Management Information Systems to an 8 percentage point increase in Efforts to Reduce Healthcare Disparities. In 2018, Access had the lowest average compliance score at 67% and four standards (Quality Assessment and Performance Improvement, Committee Structure, Satisfaction, and Enrollee Rights and Responsibilities) had a score of 100%. Satisfaction was not subject to review for ABHNJ, AGNJ, and UHCCP.

Performance Measures

2018 Core Medicaid Performance Measures

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

Overall, NJ weighted rates remained relatively constant between MY 2016 and MY 2017 (with a < 5 percentage point change year over year) for most measures. Significant increases (≥ 5 percentage point change) in performance from MY 2016 to MY 2017 were noted for one or more rates of the Comprehensive Diabetes Care (CDC), Controlling High Blood Pressure (CBP), Immunizations for Adolescents (IMA), Appropriate Testing for Children with Pharyngitis (CWP) and the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures. Significant decreases (≥ 5 percentage point change) in performance from MY 2016 to MY 2017 were noted for both rates of the Follow-up After Hospitalization for Mental Illness (FUH) measure.

2018 New Jersey State-Specific Performance Measures and Core Set Measures

As more patients with disabilities and chronic conditions transition to managed care from Fee-for-Service (FFS), three performance measures were developed by IPRO, in conjunction with DMAHS. Two of these measures are HEDIS measures – AAP and CAP – that are reported for the Dual Eligibles, Disabled and Other Low Income subpopulations. The intent of these breakouts is to assist in identifying areas in need of improvement for reducing disparities in care. The third measure, also reported at the total and subpopulation level, is Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit). This is a custom measure.

Developmental Screening in The First Three Years of Life (Developmental Screening) was added to MY 2017 and is defined by age groups: 1 year old, 2 year old, and 3 year old.

2018 MLTSS Performance Measure Validation

During July 1, 2016–June 30, 2017, IPRO worked closely with DMAHS Office of MLTSS Quality Monitoring and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications for the July 2017–June 2018 measurement period were developed for the following PMs: #4: Timeliness of Nursing Facility (NF) Level of Care Assessment by MCO; #18: Critical Incident Reporting, #20: Total Number of MLTSS Members Receiving MLTSS Services; #21: MLTSS Members Transitioned from NF to Community; #22: New NF Living Arrangement for MLTSS Members; #23: NF to Home- and Community-Based Services (HCBS) Transitions who Returned to NF within 90 Days: #24: MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days; #25: MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less; #26 and #27: Acute Inpatient Utilization by MLTSS Members; #28: Readmissions of MLTSS HCBS Members to Hospital within 30 Days; #29: Readmissions of MLTSS NF Members to Hospital within 30 Days; #30 and #31: ER Utilization by MLTSS Members; #33, #34 and #41: MLTSS Services Used by MLTSS HCBS Members; #36: Follow-Up After Mental Health Hospitalization for MLTSS HCBS Members; #38: Follow-Up After Mental Health Hospitalization for NF Members; #39 and #40: MLTSS Members with Select Behavioral Health Diagnoses; #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS Members; #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS NF Members; #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members; and #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members.

Measures requiring claims have an 8-month lag from the last date of the measurement period to the reporting period, allowing for a 6-month claim lag, 1-month period for report development and 1 month for reporting. The timeframe for the MY 2018 reports ran through February 2019, which is outside the scope of this report.

Following the release of NCQA's *Rules for Allowable Adjustments of HEDIS 2019*, in the 4th quarter of 2018, IPRO worked with DMAHS to ensure that HEDIS-based measures followed the NCQA guidance. For the upcoming year, 2019 specifications directed the MCOs to produce the following measures following HEDIS methodology and reporting the unmodified HEDIS measure for the MLTSS subpopulations of interest:
#26, #27 – IPU (Inpatient Utilization—General Hospital/Acute Care)
#28, #29 – PCR (Plan All-Cause Readmissions)
#30, #31 – AMB (Ambulatory Care)
#36, #38 – FUH (Follow-up After Hospitalization for Mental Illness)
#42, #43 – FUA (Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence)
#44, #45 – FUM (Follow-up After Emergency Department Visit for Mental Illness)

2018 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the plan of care (POC). This measure ensures HCBS MLTSS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. In 2016, 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. In 2017, IPRO calculated PM #13, using POCs and claims data.

In July 1, 2016–June 30, 2017, IPRO undertook an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (blackout periods). A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and blackout period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2016 and June 30, 2017.

The MLTSS services assessed in this methodology were: Adult Family Care, Assisted Living Services/Program, Chore Services, Cognitive Therapy, Community Residential Services, Home Delivered Meals, Medical Day Services, Non-Medical Transportation, Medication Dispensing Device Monthly Monitoring, Occupational Therapy, PCA/Home Based Supportive Care, PERS Monitoring, Physical Therapy, Private Duty Nursing, Social Adult Day Care, Speech, Language and Hearing Therapy, Structured Day Program, Supported Day Services, and TBI Behavioral Management.

The overall compliance rate for PM #13 was 32.4%, which was an improvement over the rate of 25.3% observed in the prior year. WCHP had the lowest compliance rate, with a rate of 24.4%. The highest compliance rate was achieved by AGNJ, with a rate of 37.4%. More eligible records were submitted by each of the MCOs compared to the prior year.

Core Medicaid/MLTSS Performance Improvement Projects

For January 2018-December 2018, this QTR includes IPRO's evaluation of the April 2018 and August 2018 PIP report submissions and Fall 2018 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols.

DMAHS Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State encounter data unit 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 Encounter Data Monitoring Unit (EDMU) calls with the MCOs.

Focused Quality Studies

2018 Behavioral Health Transportation Focused Study

At the request of DMAHS, IPRO undertook a review of transportation services provided to the Medicaid beneficiaries accessing behavioral health services in New Jersey.

Two types of phone surveys were done for beneficiaries that had scheduled a trip with LogistiCare, the transportation provider. The first survey was for beneficiaries that had a completed trip. The purpose of this survey was to assess the beneficiary's satisfaction with the trip itself, and the beneficiary's satisfaction with LogistiCare. The second survey was for beneficiaries that had scheduled a trip, but the trip was canceled. The purpose of this survey was to determine the reasons for cancelations and to assess satisfaction with rescheduling the appointment.

A total of 326 phone calls were made to reach beneficiaries who had had a completed trip (from residence to appointment, sometimes referred to as an A-leg trip) and a total of 156 phone calls were made to reach beneficiaries who had had a canceled trip.

The majority of the beneficiaries who were surveyed about their completed trip were satisfied with the time the vehicle arrived to pick them up, with an 86.1% satisfaction rate in North New Jersey, 86.7% in Central New Jersey, and 84.3% in South New Jersey, and 85.8% statewide. Out of 41 beneficiaries who were not satisfied with the pick-up time, 73.2% of the beneficiaries were late to the appointment.

For the canceled trips, 78.5% of respondents stated that they were responsible for canceling the trip, while 6.9% stated that the doctor canceled the trip, 3.8% stated the vehicle never arrived, and 10.8% gave another reason. Due to only two beneficiaries experiencing a vehicle not showing and rescheduling their trip, no analysis was conducted to evaluate assistance from LogistiCare.

CAHPS 2018 Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide Children's Health Insurance Program (CHIP)-only survey. All of the members surveyed required continuous enrollment from July 1, 2017 through December 31, 2017, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey.

Care Management Audits

2018 Core Medicaid Care Management Audits

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

The MY 2017 rates across all MCOs, populations, and categories ranged from 70% to 100%. Scores for Continuity of Care and Coordination of Services were above 90% for all five MCOs for all (GP, DDD, DCP&P) populations in 2017. Scores for Identification for the DDD and DCP&P populations were all above 90% across all five MCOs in 2017.

Five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD, DCP&P, and GP) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 75 scores. Out of the five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) across the General, DDD and DCP&P populations and across five plans that were

comparable to 2016 (75 in total), twenty-four (24) scored higher, twenty-four (24) remained the same, and twenty-seven (27) scored lower in MY 2017.

2018 MLTSS HCBS Care Management Audits

The purpose of the annual MLTSS HCBS CM audit was to continue to evaluate the effectiveness of the contractually required MLTSS CM programs of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or CARS within the review period from 7/1/2017 through 6/30/2018. The results from the previous review period (7/1/2016–6/30/2017) were compared to the 2018 audit, which includes the new results from 7/1/2017–6/30/2018.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated July 2017. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/17 and 1/1/18 (Group C) and existing MMC members enrolled in MLTSS between 7/1/17 and 1/1/18 (Group D), the 2018 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/17) and continuously enrolled with the MCO in MLTSS through 6/30/18. A minimum of 100 files were to be reviewed and abstracted across all three groups. An oversample was selected for the MCO to replace any excluded files.

Across all plans, the total NJ weighted average for the 7/1/2017–6/30/2018 audit results for Groups C, D and E ranged from 7.6% for PM#11 Plans of care developed using "person-centered principles" to 96.2% PM #16 Member training on identifying/reporting critical incidents.

2018 MLTSS Nursing Facility Care Management Audits

The purpose of the MLTSS NF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in an NF or SCNF for at least six consecutive months within the review period from 7/1/2016 through 6/30/2017. IPRO prepared an audit tool structured to collect requirement-specific information related to three categories: 1) A Plan of Care for Institutional Settings; 2) NF/SCNF Members Transferred to HCBS; and 3) HCBS Members Transferred to the NF/SCNF. The "Plan of Care for Institutional Settings" category was identified as the audit focus.

Across all five MCOs in the "Plan of Care for Institutional Settings" category, three MCOs scored above 85% and two scored below 85% for demonstrating coordination of care. Three of the five MCOs scored above 90% for having the member present and included in onsite visits by the care manager. All five MCOs have an opportunity for improvement to include copies of facility plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility interdisciplinary team (IDT) meetings and timely onsite review for member placement and services. Two MCOs had members that fell in the "NF/SCNF Member Transferred to HCBS" category. Three review elements scored above 85% for one MCO. One of the two MCOs scored 33% for having a New Jersey Choice Assessment completed to reassess a member for NF/SCNF member transferred to HCBS. It was noted that one MCO scored 100% in three of the eight review elements, and one MCO scored 67% in three of the eight review elements; however, caution should be taken while interpreting these results due to the low number of care

management records reviewed for some of the elements. One MCO had an opportunity for improvement in IDT meeting attendance pertaining to member transfer to an HCBS setting. Two MCOs had an opportunity to amend the POCs prior to discharge from the facility. Only two MCOs had members that fell in the "HCBS Members Transferred to an NF/SCNF" category. As a result, a comparison could not be made across MCOs. Both MCOs documented a discussion with the member prior to change of service/placement.

Conclusion and MCO Recommendations

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

CHAPTER 1 – INTRODUCTION

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

DMAHS has contracted with IPRO to serve as its EQRO. As a part of this contract, IPRO assesses MCO operations and performance on key activities and provides recommendations on how these activities can improve the timeliness, quality, and access to healthcare services for enrollees. This report is the result of IPRO's assessment and review of MCO activities for the period from January 2018 through December 2018.

Background

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. As of December 2018, there were approximately 1,626,991 individuals enrolled in MMC and the number decreased from 1,650,804 in December 2017 (**Table 1**). Of the 1,626,991 individuals enrolled in MMC, 47,375 were receiving MLTSS services as of December 2018. Approximately 90% of managed care eligible beneficiaries receive services through the managed care program.

New Jersey 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).

In 2011, NJ applied for a five-year Medicaid and CHIP Section 1115 research and demonstration waiver encompassing nearly all services and eligible populations served under a single authority. In October 2012, CMS approved NJ's request for the new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver." Under this demonstration, NJ will operate a statewide health reform effort that will expand existing managed care programs to include MLTSS and expand HCBS to some populations. Implementation of the MLTSS HCBS and NF services for new MLTSS members began in July 2014. The New Jersey Comprehensive 1115 Waiver was submitted to CMS in March 2017 and approved in August 2017. MLTSS enrollment was approximately 47,375 as of December 2018 (**Table 1**).

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Medicaid and MLTSS in January 2018–December 2018. **Table 1** presents respective enrollment figures in December 2017 and December 2018.

Table 1: 2017–2018 MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2017	December 2018	December 2017	December 2018
Aetna Better Health of New Jersey	ABHNJ	40,264	51,588	2,212	3,099
Amerigroup New Jersey, Inc.	AGNJ	192,745	177,498	6,999	7,167
Horizon NJ Health	HNJH	871,766	861,174	16,822	19,411
UnitedHealthcare Community Plan	UHCCP	481,836	467,877	7,597	9,113
WellCare Health Plans of New Jersey, Inc.	WCHP	64,193	68,854	6,343	8,585
Total		**1,650,804**	**1,626,991**	**39,973**	**47,375**

[1]Managed Long Term Services and Supports (MLTSS) members are included in the December 2017–2018 Medicaid enrollment figures.
Source: DMAHS

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid including MLTSS-eligible enrollment for December 2017 and December 2018 in relation to the entire NJ MMC population.

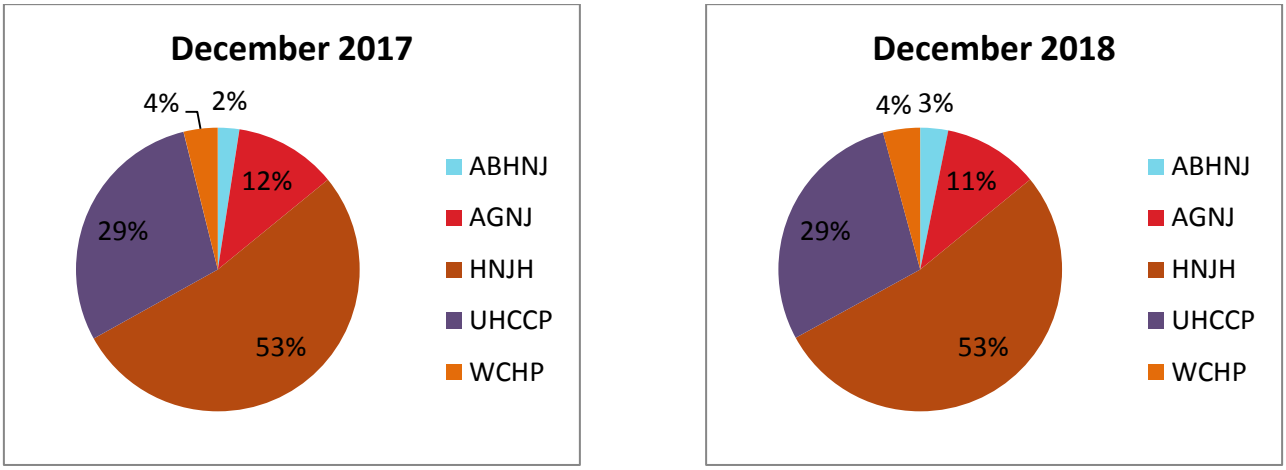

Figure 1: 2017–2018 Medicaid Managed Care Enrollment by MCO. Enrollment in MMC for each MCO reported in **Table 1** as of December 2017 (left panel) and December 2018 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (beige); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (green); UHCCP: UnitedHealthcare Community Plan (purple); WCHP: WellCare Health Plans of New Jersey, Inc. (orange). Percentages may not add to 100% due to rounding.

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

Table 2: 2018 EQR Activities by MCO

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

EQR: external quality review; MCO: managed care organization; PM: performance measure; MLTSS: Managed Long Term Services and Supports; PIP: performance improvement project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: care management; HCBS: home and community based services; NF: nursing facility.

Purpose and Objectives

The purpose of this QTR is to: 1) discuss the results of the quality assessments performed during 2018 in accordance with the BBA [Subpart E, 42 CFR, Section 438.364], 2) review the strengths and weaknesses of each MCO, 3) provide recommendations for performance improvement, and 4) establish a foundation for enhancing the quality-of-care services provided to publicly funded programs in NJ. This report provides comprehensive insight about the performance of the State's MCOs on key indicators of healthcare quality for NJ FamilyCare Managed Care enrollees.

External Quality Review Activities

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

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

Table 3: Mandatory EQR-Related Activities

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

In addition, IPRO completed one non-clinical focused study, and fielded the 2018 CAHPS survey for the Medicaid population. IPRO also completed Core Medicaid, MLTSS HCBS and MLTSS NF CM audits to evaluate the effectiveness of the MCOs' Core Medicaid and MLTSS CM programs.

MCO Strength and Weakness Evaluation

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

Strengths

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

Weaknesses

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

Components of Care: Quality, Access, and Timeliness

IPRO used 2018 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

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

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

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

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

CHAPTER 2 – STATE INITIATIVES

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

This chapter provides information on initiatives that DMAHS is undertaking to improve quality of care and information technology. DMAHS has been active in the New Jersey Medicaid Accountable Care Demonstration (ACO) Project; Health Information Technology (HIT); Medicaid Information Technology Architecture Project and Master Client Index Project; Medicaid Innovator Accelerator Program; Community Based Care Management; and National Core Indicators for Aging and Disabilities (NCI-AD). To implement our vision, New Jersey has focused on providing all of our members with quality care and services through increased access and appropriate, timely utilization of health care services. The goals of our Quality Strategy, which include to improve timely, appropriate access to primary, preventative, and long term services and supports for adults and children; to improve the quality of care and services; to promote person-centered health care and social services and supports; and to assure member satisfaction with services and improve quality of life, guide the below initiatives in direction and scope.

The New Jersey Medicaid Accountable Care Demonstration Project

In August 2011, Governor Christie signed into law (NJ P.L. 2011, Chap 114) requiring DMAHS to establish a three year Medicaid Accountable Care Organization (ACO) Demonstration project designed to improve health outcomes, quality and access to care through regional collaboration, and shared accountability while reducing costs. The NJ Medicaid ACO Demonstration provides Medicaid an opportunity to explore innovative system re-design, including: testing the ACO as an alternative to managed care; rethinking how care management and care coordination should be delivered to high risk, high cost utilizers; stretching the role of Medicaid beyond just medical services but to integrate social services as well; and finally, testing payment reform in terms of pay for performance metrics and incentives. DMAHS launched the Demonstration in July 2015, which was to conclude in June 2018, but the Demonstration was extended for one year for transitional purposes. A baseline report from year one of the Demonstration has been published. Reports from both year two and three are anticipated to be published in 2019.

Health Information Technology

DMAHS recognizes the critical role of health information technology (HIT) as a transformation enabler. Current challenges in health system integration arising from information silos have impeded care coordination and resulted in duplication of services, medical errors, and administrative inefficiencies. The Medicaid Management Information System (MMIS) is an important component of program operations that is vital to advancing the goals of DMAHS and other agencies that comprise the Medicaid enterprise to provide services that are cost-effective and result in high quality outcomes.

In February 2015, DMAHS awarded the contract for the Replacement MMIS to Molina Medicaid Solutions, now DXC Technology. The Design, Development, and Implementation phase began in mid-2015, with a planned late 2019 implementation timeline. Currently, Phase 3 (Requirements Analysis and Design) of the System Development Life Cycle is nearing completion, and tasks and activities for Phase 4 (Development and Test) and Phase 5 (Implementation and Readiness) have already begun. Multiple phases run concurrently in this agile deployment. The goal of the project is to provide DMAHS with the system infrastructure, technical capabilities, and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation.

The new system, referred to as the Replacement MMIS, will help ensure that members receive quality, coordinated, and person-centered health services, that programs are effectively administered with the help of decision support tools, and that fraud, waste, and abuse are prevented, detected, and addressed. The Replacement MMIS will enable NJ to achieve program goals that are critically intertwined with health information technology and electronic exchange of data to improve health outcomes and control program costs.

DMAHS aims to implement an agile information system that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the Replacement MMIS will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system.

The Replacement MMIS will take advantage of new technologies to enable the following:

- Support of dynamic business processes, allowing for the necessary expansion of all system maintained data elements and fields to accommodate expanding scope, new services, changing requirements, and legislative mandates;
- Significant reduction of paper-based processing thus reducing paper waste and also provide economical data archiving by using an Electronic Document Management System (EDMS);
- Better, faster, and easier-to-use technology with less operating and maintenance costs, better financial modeling, budgeting tools, and expenditure control practices;
- Better communication and data sharing bridges among internal and external users to improve care and member management; and
- Improved customer service and decision-making tools, enhanced reporting, and better use of staff.

Anticipated Benefits

The new capabilities will allow DMAHS to:

- Ensure provision of coordinated, accountable and patient-focused care;
- Facilitate data access and health information exchange in real time while ensuring privacy and security;
- Coordinate with other public health agencies to improve surveillance and population health;
- Determine availability of services to improve access to care;
- Promote informed and timely decision-making, both at the policy administration level and at the point of care;
- Provide data that are timely, accurate, usable, and accessible;
- Improve healthcare outcomes by providing the right information at the right time to support clinical decisions;
- Promote member engagement in their healthcare;
- Take advantage of automation and paperless transactions;
- Accommodate current and future business methods;
- Monitor and improve programs and determine cost effectiveness;
- Monitor costs and predict future financial needs;
- Enhance prevention, detection and loss recovery related to fraud, waste and abuse;
- Compare service utilization or provider or beneficiary enrollment across State or other geographic boundaries;
- Participate in health information exchange and the Health Insurance Exchange;
- Leverage resources by maximizing the use of shared services;
- Keep pace with technological innovations that will reduce operating and maintenance costs; and
- While enabling better program administration and expenditure control practices.

The Replacement MMIS provides possibilities for business improvement and the flexibility to accommodate evolving business needs and methods. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Information Technology Architecture Project and Master Client Index Project

In addition to the Replacement MMIS project DMAHS established an Enterprise Master Client Index (MCI) in May 2015, linking the NJ Medicaid Management Information Systems (MMIS) with the NJ Department of Health (DOH) Blood Lead Registry and the DOH Immunization Registry. The MCI will be integrated with the new Replacement MMIS project for MMIS identity management and to meet RMMIS bi-directional data exchange requirements with NJ State Health Registries. The MCI is a Master Data Management (MDM) project providing identity management necessary to link client data that resides in disparate system databases for the same person where the patient demographics lack 100% consistency with regard to format and content. The MCI is used to cross reference client identifiers across each

participating information system to uniquely identify each client, perform global searches and matching, consolidate duplicate client records, and create complete views of client information and share data easily across multiple facilities and information systems.

DMAHS now utilizes the MCI as the source of all legacy MMIS member identity management particularly for all client eligibility data sent to the MMIS. A new Replacement MMIS (RMMIS) is now under development and is expected to be completed in late 2019. The MCI will be integrated with the new RMMIS system and be utilized for all RMMIS identity management and to meet RMMIS bi-directional data exchange requirements with NJ State Health Registries.

Health Information Exchange (HIE) has been ongoing between DMAHS and NJ DOH for blood lead screening information for over 11 years through bi-annual data matching. Through this process, DMAHS has been able to identify children with elevated blood levels or children who have not received a blood lead screening and share this information with contracted MCOs so that necessary follow-up is initiated. With the new RMMIS project under development, efforts are underway to make the data exchange more automated, accurate and closer to real-time. The MCI project is key to this HIE initiative and will facilitate other efforts related to the Health Information Technology and the collection of quality measures required by Children Health Insurance Program Reauthorization Act (CHIPRA). It is anticipated that as the information infrastructure matures, the ability to provide real time patient information at the point of care to improve quality and safety will also be vastly improved. The eventual measurement and standardization of quality indicators will also help in assessing program performance, increase transparency, provide valuable information to providers on their performance on key areas and encourage adherence to evidence-based guidelines.

Medicaid Innovation Accelerator Program

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

Medicaid Innovation Accelerator Program (IAP): Overview

Value Based Payment and Financial Simulations:

Under the Value Based Payment (VBP) and financial simulation IAP, selected states received technical support for states interested in designing, developing, or implementing Value-Based Payment approaches (i.e. payment models that range from rewarding for performance in fee-for-service (FFS) to capitation, including alternative payment models and comprehensive population-based payments.

The content of one-on-one technical support delivery for selected states is refined based on selected states' specific needs. States were able to identify the technical support that best meets their needs, such as:

- Strategic design, drilling down into states' payment model goals, objectives, and technical support needs
- Development of Value-Based Payment approaches in Medicaid
- Implementation of agreed upon Value-Based Payment approaches in Medicaid
- Assistance in developing financial simulations of state-developed Value-Based Payment approaches

Under the Medicaid Innovation Accelerator Program (IAP) Value-Based Payment (VBP) and Financial Simulations component, New Jersey explored a bundled payment approach to VBP within their Managed Care Organization (MCO) program. The New Jersey initiative involved a simulation bundled payment arrangement for pediatric asthma services provided to MCO enrollees.

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

The goal for this IAP opportunity is to support states as they design, develop, and implement Medicaid VBP models and/or enhance and expand existing state Medicaid payment reform.

This one-on-one technical support program will include peer-to-peer learning opportunities and tailored coaching focused on two key objectives:

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

States will participate in peer-to-peer learning opportunities and receive individual technical support around designing and implementing a VBP strategy for HCBS in the following areas:

- Aligning financial incentives in a VBP for HCBS strategy with overall state policy objectives for HCBS:
- Engaging with stakeholders to ensure a VBP strategy for HCBS is widely understood and supported;
- Developing a measurement strategy, including selecting HCBS outcome and quality measures, determining accountable entities, and identifying beneficiary population and attribution models;
- Designing an approach to collect and analyze baseline data, and measuring performance within the VBP for HCBS strategy;
- Designing VBP for HCBS strategies that offer both financial and non-financial incentives;
- Distributing incentive payments in accordance with performance on selected metrics;
- Monitoring the impacts of the VBP for HCBS strategy on providers and managed long-term service and supports plans; and
- Implementing strategies to expand successful VBP for HCBS strategies to new populations, programs, or providers

For this TA, NJ is focusing on the improvement of the delivery of services and member satisfaction/experience for community-dwelling individuals receiving HCBS services. Additionally, New Jersey hopes to benefit from this TA to assist in the development of a communication/ messaging plan to make sure both of the VBP strategies and any new opportunity is understood by all internal and external stakeholders.

Medicaid Innovator Accelerator Program (IAP): Opioid Data Analytics Cohort

The Opioid Data Analytics Cohort is comprised of three primary components that run sequentially and are designed to build on one another.

- Under the opioid use disorder (OUD) component of the data analytics cohort, selected states will focus on sizing and stratifying the magnitude of the opioid epidemic within the Medicaid population. Throughout this component, participating states will receive tools and resources including: a data template; diagnosis and procedure codes for identifying OUD in Medicaid claims; and ongoing technical support. The aim of the OUD component is to help states better understand the scope of the opioid problem in Medicaid programs, the expenditure patterns of the OUD population, and the characteristics of the affected population across key dimensions, including age, gender and other demography, in order to better inform data-driven strategies and support development of targeted interventions.

  New Jersey was interested in participating in the OUD component to assist with the New Jersey's goal to better collect, share, report and analyze the data we collect with the potential of an Opioid/SUD dashboard. The 1115 SUD waiver also includes a statewide HIT plan that involves partnering with Dept. of Health, Division of Community Affairs, the state's Prescription Drug Monitoring Program, Division of Mental Health and Addictions, and the NJ Health Information Network.

- Under the Medication-assisted treatment (MAT) component of the data analytics cohort, selected states will focus on assessing the availability and distribution of MAT within the state's Medicaid program. Throughout this component, participating states will receive tools and technical resources including: value sets to identify MAT utilization in Medicaid claims; table shells; a list of all buprenorphine-waivered practitioners in the state; and ongoing technical support. The aim of the MAT component is to better understand the characteristics of MAT in the state across key dimensions, including geography, participation in Medicaid of buprenorphine-waivered practitioners, penetration rates, caseloads of waivered practitioners and utilization of concomitant services such as individual or group counseling or other types of recovery supports, in order to better inform data-driven strategies

and support states to improve access and quality of care. New Jersey is currently using the data to inform an improved Office based addictions treatment benefit and increase access to MAT treatment services provided by buprenorphine-waivered practitioners.

New Jersey was interested in participating in this component to assist in efforts to share data, and monitor Opioid Use Disorder/Substance Use Disorder (OUD/SUD) across systems for improved health and recovery and a potential reduction in Overdose deaths in NJ.

- Under the Neo-natal abstinence syndrome (NAS) and OUD care for pregnant women in the Medicaid program component of the data analytics cohort, selected states are focusing on assessing the size and characteristics of NAS and opioid-related maternity care within the state's Medicaid program. During this component, states will receive tools and technical support, including table shells and value sets to identify NAS care to infants and OUD maternity care to women. The aim of the NAS component is to help states understand where treatment occurs, what type of OUD maternity care and NAS treatment are utilized, and costs to Medicaid, in order to better inform data-driven strategies and support development of targeted interventions. In its evaluation of neonatal abstinence syndrome, New Jersey was able to leverage the program developed under its Data Analytics IAP to match infants' Medicaid eligibility data to Bureau of Vital Statistics (BVS) electronic birth records data. As a result of this process, a greater number of infants' claims were able to be evaluated for neonatal abstinence syndrome along with maternal claims.

- New Jersey Department of Human Services (DHS) and the Department of Health are looking deeper at the State maternal and infant health statistics and looking at ways we can improve these health outcomes. Of particular interest to DHS is the work around Neo-Natal Abstinence Syndrome and Opioid Maternity Care Analytics. New Jersey has a large interagency NAS workgroup underway looking at using a project ECHO model to provide training and education throughout the maternal and infant health/early childhood delivery system.

- As part of the Medicaid and CHIP Business Information Solutions (MACBIS) sponsored Medicaid Innovation Accelerator Program (IAP), New Jersey Division of Medical Assistance and Health Services (DMAHS) was provided technical support to develop a program to match infants' Medicaid eligibility data to Bureau of Vital Statistics (BVS) electronic birth certification data. New Jersey DMAHS previous linkage efforts yielded match rates less than 75%. CMS developed a complementary process using Python programming language to increase returned matches.

Community Based Care Management Demonstration

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

The MCOs were provided a template by DMAHS from which to design programs that would provide community based care management for 10% of their non-MLTSS members whose high needs require intensive, in-person interventions to assure that the selected members are making progress with their care plans. The new programs were implemented beginning January 1, 2016. DMAHS is currently in its second year of tracking and trending outcomes to determine the program's effectiveness. Community Based Care Management is intended to enhance the Plans' existing Care Management programs that were implemented in 2012.

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

NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), the Human Services Research Institute (HSRI), state Medicaid, and aging and disability agencies. New Jersey voluntarily participates in this extensive, confidential, face to face consumer survey which focuses on people with physical disabilities and on older adults. The purpose of the survey is to procure feedback directly from service recipients regarding service satisfaction and quality of life issues. The NCI-AD survey is important to NJ because data gleaned from survey participants can be measured, tracked, and applied to future State initiatives. The MACCs (Medical Assistance Customers Centers), MLTSS Steering Committee, PACE (Program of All-Inclusive Care for the Elderly), NJ Hospital

Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey, as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy. New Jersey first partnered with NCI-AD in 2015 and surveyed over seven hundred people. In 2017-2018, over 800 residents were surveyed, including MLTSS members, both in the community and in NFs, and PACE members. Participants in the survey were individuals who have been receiving long term services and supports for a minimum of six months. Recipients were assessed regarding the outcomes of services they received with the goal of assisting the State to improve the quality of services and supports that are provided to NJ residents. Surveyors received annual training regarding the survey process inclusive of creating a positive survey experience, interview techniques for older adults and people with disabilities, the use of proxy assistance, and mandatory reporting requirements. The 2017-2018 survey contained approximately ninety questions that included the domains of: home, relationships, service satisfaction, direct care workers, daily activities, physical environment, safety/security/privacy, community, everyday living, health and wellness, healthcare, future planning, and independence. New Jersey also created twelve questions unique to the State that addressed specific concerns relevant to NJ and its residents. These included the categories of member needs, in-home assistance, home delivered meals, and individualized plans of care. At the end of the survey interviewers provide feedback and any unmet needs that the individual identified and wished to have addressed were noted and appropriate follow-up was performed. As participating states measure and track their own performance, NJ State-specific performance reports regarding core indicators are available for year over year comparison, along with additional information regarding the NCI-AD survey process, on the NCI-AD website, www.nci-ad.org.

CHAPTER 3 – SUMMARY OF KEY FINDINGS

This chapter provides a review of key findings from January 2018–December 2018 EQR activities, including the annual assessment of MCO operations, validation of performance measures, validation of PIPs, Core Medicaid care management audits, MLTSS care management audits, focused studies, and CAHPS surveys. ABHNJ, AGNJ, HNJH, UHCCP, and WCHP participated in all of these EQR activities.

2018 Annual Assessment of MCO Operations

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

The methodology was not changed from 2017 annual assessments. Staff interview questions were not provided prior to the onsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the onsite interview. The plan was provided with an opportunity to clarify responses and to provide requested documentation during the onsite.

The specific number of requirements for which each MCO is reviewed depends on its performance during the previous year's assessment. The annual assessment process allows for a partial review for MCOs that meet a minimum compliance rate of 85% in the previous review period. MCOs entering the market in NJ have two consecutive full assessments, and some elements (e.g., CM7, CM8, CM19, QM11, QM18 and MLTSS elements) are reviewed annually regardless of prior year's score. MCOs with a compliance rate less than 85% or which already had a partial review in the prior year's assessment undergo a comprehensive review of all requirements in the current year. MCOs with a compliance rate of 85% or better are subject to a partial review that focuses only on those areas that needed improvement, specifically, those elements that were either Not Met or Not Applicable during the previous review. 2018 included a partial review of ABHNJ, AGNJ, HNJH, and UHCCP, as they underwent a full review in 2017. WCHP had a full review in 2018, as it had a partial review in 2017. This review evaluated each health plan on 14 standards based on contractual requirements (total of 237 elements). The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2018 is outlined in **Table 4**.

Table 4: 2018 Annual Assessment Type by MCO

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

Assessment Methodology

IPRO reviewed each MCO in accordance with the 2012 CMS protocol, "EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations."

The review consisted of pre-onsite review of documentation provided by the plan as evidence of compliance with the 14 standards under review; onsite review of randomly selected files; onsite interviews with key staff and post-onsite evaluation of documentation and onsite activities. To assist in submission of appropriate documentation, IPRO developed the Annual Assessment of MCO Operations Review Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and

organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. In 2018, one new element in Quality Management and one new element in Care Management and Continuity of Care were added. Moreover, A4 in Access, CM18 in Care Management and Continuity of Care, and UM16 in Utilization Management were split into 7, 4, and 11 different elements, respectively, and these elements were reviewed separately for the first time in 2018. 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, 2017 to June 30, 2018.

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

IPRO reviewers conducted onsite file reviews for all MCOs. Select files were examined for evidence of implementation of contractual requirements related to credentialing, recredentialing, and utilization management, as well as member and provider grievances and appeals. Separate file sets were selected to review Core Medicaid and MLTSS requirements. File reviews utilized the eight and thirty file sampling methodology established by the NCQA.[2]

During the onsite audit, IPRO conducted a full review of each MCO's call center systems. Each MCO was required to present a live demonstration of the processes and flow of their call center system, showing how the call center system links with the other management systems to coordinate and provide services efficiently to the NJ FamilyCare MMC enrollees.

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, Web site, Notice of Action (NOA) letters, and the Employee Handbook.
- ***Implementation:*** IPRO evaluated documents for evidence that the MCO's policies and procedures have been implemented. IPRO reviewed documents including committee meeting minutes, organizational charts, job descriptions, program descriptions, flow charts, tracking reports and, file reviews as applicable.

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

[2] IPRO reviews an initial sample of eight files, and then reviews an additional sample of twenty-two files when any of the original eight fail the review, for a total of thirty records.

Summary of Comparative Results

Table 5 displays a comparison of the overall compliance score for each of the five MCOs from 2017 to 2018. In July 1, 2017–June 30, 2018, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2018 compliance scores from the annual assessment ranged from 91% to 97% (**Table 5**). HNJH's compliance score increased 6 percentage points from 91% to 97% in 2018. ABHNJ's compliance score increased from 87% to 91% in 2018 (**Table 5**). Access, Care Management and Continuity of Care, and Utilization Management had one previous element split into 4, 7, and 11 elements, respectively, and hence the compliance scores for these standards cannot be directly compared to those in 2017. One standard (Credentialing and Recredentialing) decreased 2 percentage points from an average compliance score of 96% in 2017 to 94% in 2018 (**Table 6**). Average compliance for three standards (Committee Structure, Provider Training and Performance, and Enrollee Rights and Responsibilities) remained the same from 2017 to 2018. Average compliance for the remaining seven standards showed slight increases ranging from 2 percentage point increases each for Quality Assessment and Performance Improvement, and Management Information Systems to an 8 percentage point increase in Efforts to Reduce Healthcare Disparities (**Table 6**). In 2018, Access had the lowest average compliance score at 67% and four standards (Quality Assessment and Performance Improvement, Committee Structure, Satisfaction, and Enrollee Rights and Responsibilities) had a score of 100%. Satisfaction was not subject to review for ABHNJ, AGNJ, and UHCCP.

Table 5: Comparison of 2017 and 2018 Compliance Scores by MCO

MCO	2017 Compliance %	2018 Compliance %	% Point Change from 2017 to 2018
ABHNJ	87%	91%	+4
AGNJ	94%	95%	+1
HNJH	91%	97%	+6
UHCCP	92%	93%	+1
WCHP	98%	96%	-2

Table 6: 2017 and 2018 Compliance Scores by Review Category

Review Category	MCO Average 2017	MCO Average 2018	Percentage Point Change
Access	85%	67%	N/A
Quality Assessment and Performance Improvement	98%	100%	+2
Quality Management	90%	94%	+4
Efforts to Reduce Healthcare Disparities	76%	84%	+8
Committee Structure	100%	100%	0
Programs for the Elderly and Disabled	90%	96%	+6
Provider Training and Performance	96%	96%	0
Satisfaction	95%	100%[1]	+5
Enrollee Rights and Responsibilities	100%	100%	0
Care Management and Continuity of Care	95%	97%	N/A
Credentialing and Recredentialing	96%	94%	-2
Utilization Management	88%	92%	N/A
Administration and Operations	91%	97%	+6
Management Information Systems	97%	99%	+2
TOTAL	**92%[2]**	**94%[2]**	**+2**

[1] Satisfaction was not subject to review in 2018 for ABHNJ, AGNJ, and UHCCP.

[2] Total is the average of compliance scores listed in **Table 5**.

N/A: Due to changes in number of elements, the compliance score for this standard cannot be directly compared to previous year's score.

Figure 2 depicts compliance scores since 2016. Compliance scores for AGNJ, HNJH and UHCCP have remained above 90% for all three years. ABHNJ's compliance score has increased each year since 2016. WCHP's compliance score increased to above 90% in 2017 and remained above 90% in 2018.

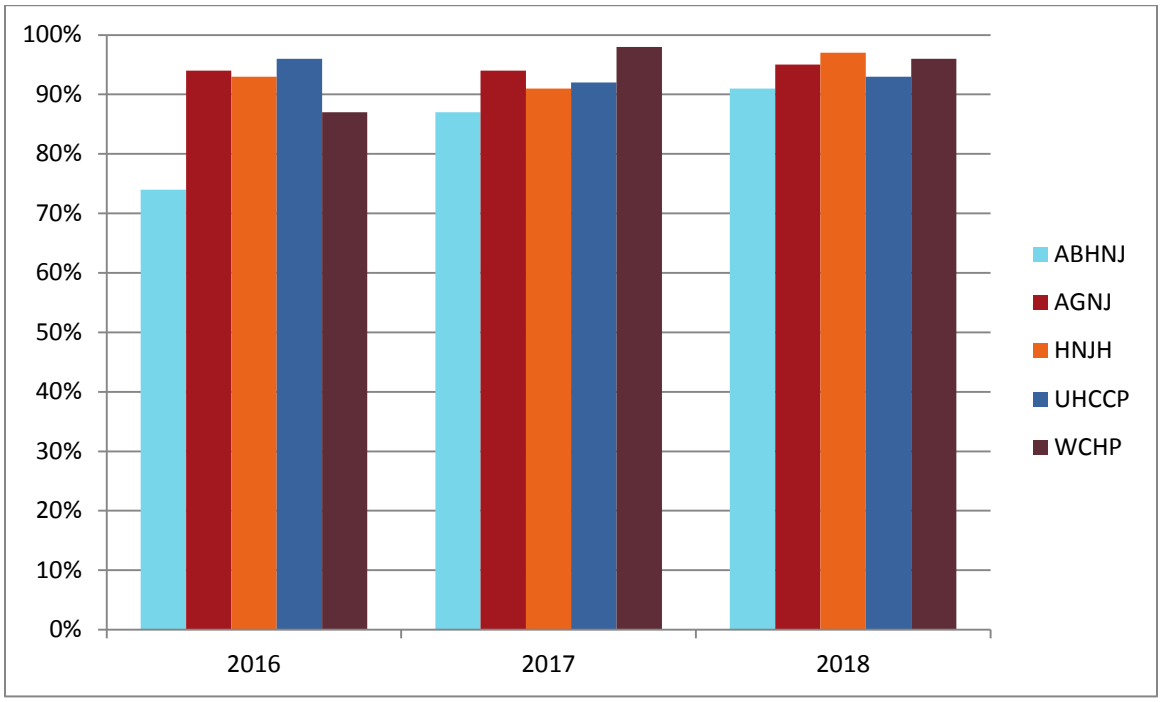

Figure 2: MCO Compliance Scores by Year (2016–2018). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, lite blue); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, orange), UnitedHealthcare Community Plan (UHCCP, blue); and WellCare Health Plans of New Jersey, Inc. (WCHP, burgundy) are shown for 2016–2018.

During the onsite audit, IPRO conducted a full review of each MCO's call center systems. Each MCO was required to present a live demonstration of the processes and flow of their call center system, showing how the call center system links with the other management systems to coordinate and provide services efficiently to the NJ FamilyCare MMC enrollees. HNJH and UHCCP had deficiencies regarding their call center processes. HNJH's grievance system was separate from the call center system and grievances were entered manually into HNJH's system. A real-time report that was reviewed on site showed a substantial number of pended cases in the call center systems with dates of calls that were older than 30 days. In addition, HNJH's call center desk-top procedures lacked explicit steps for determining if PCP change requests were related to dissatisfaction with the PCP. For UHCCP, it was unclear whether members calling to make a PCP change were consistently asked for the reason and whether the PCP change would trigger a grievance in the grievance system if the reason for the change related to a grievance regarding the PCP. Reports from UHCCP's call center were requested for review; however, it was unclear from these reports that requests for PCP changes resulted in generation of a grievance in UHCCP's grievance system.

The remaining three MCOs (ABHNJ, AGNJ and WCHP) demonstrated reliable flows of information from the call center to the MCOs. While reconciliation reports were not standard, review of current open cases did not indicate that there were backlogs. Requests for PCP changes prompted questions regarding reason for change and could trigger a grievance event. AGNJ had an automated process for routing expressions of dissatisfaction to the MCO; events for ABHNJ were closed out in the call center system by MCO staff; and WCHP's system had the option of a warm transfer for follow-up calls. All three MCOs (ABHNJ, AGNJ and WCHP) demonstrated consistent handling of calls that were potentially expressions of dissatisfaction from members, with appropriate engagement of the MCOs' appeals and grievance units.

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 2018 annual assessment of MCO operations are listed below:

- The implementation and evaluation of a comprehensive Quality Assessment and Performance Improvement (QAPI) program that meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing quality improvement activities and demonstrates ongoing initiatives.
- Enrollee rights and responsibilities comprehensively documented and communicated to members and providers via the Member Handbook, Provider Manual and the health plan's website.

Opportunities for Improvement

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

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

- Continuing efforts in provider recruitment and improving access to hospitals, dental services, and PCPs in all counties including access to and coverage of out-of-network services as necessary;
- Development of methods to monitor MLTSS HCBS provider network;
- Continuing to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers;
- Implementing planned interventions in a timely manner to have an effective impact on the outcome of the PIPs;
- Continuing to strengthen analytic support and address deficiencies in implementation of the PIPs;
- Formal evaluation of the outcomes of a work plan and initiatives to overcome identified healthcare disparities;
- Ensuring timely resolution of member and provider grievances and appeals;
- Continuing to ensure timely and adequate outreach is made and the outreach attempts are tracked, monitored, and reported for initial health screens and comprehensive needs assessments as appropriate;

2018 Performance Measures

2018 Core Medicaid Performance Measures

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

Background

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

Assessment Methodology

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable. In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control

procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used and medical record review procedures relevant to the calculation of the hybrid measures.

Evaluation Findings

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP); three of the five MCOs demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State. ABHNJ stated that they did not have enough population to report the Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC) measure and elected not to produce that measure. HNJH's rates were not included in the averages for measures that demonstrated potential bias greater than 10%. This potential bias was due primarily to the fact that HNJH did not successfully complete the medical record pursuits for the hybrid measures. A review of the FARs for the individual MCOs revealed that all procedures and databases used to produce HEDIS data were determined to be compliant with the NCQA specifications.

The following should be considered for valid interpretation and comparison of reported rates: for AGNJ, FIDE SNP members were not included in the HEDIS submission (due to NCQA accreditation, FIDE SNP was excluded since it's a separate product managed by AGNJ's Medicare business unit, and reported separately from Medicaid to the State and NCQA). AGNJ also did not exclude members with third party liability (TPL).

The following results were noted for the NJ Medicaid average (weighted rates). Overall, rates remained relatively constant between MY 2016 and MY 2017 (with a < 5 percentage point change year over year) for most measures. Significant increases and decreases (≥ 5 percentage point change) in performance from MY 2016 to MY 2017 are noted below.

Improvements in performance from MY 2016 to MY 2017:

- Comprehensive Diabetes Care
  - Blood Pressure Controlled < 140/90 mmHg improved by 13.50 percentage points.
- Controlling High Blood Pressure (CBP) improved by 7.83 percentage points.
- Immunizations for Adolescents (IMA)
  - HPV improved by 11.41 percentage points.
  - Combination 2 improved by 11.20 percentage points.
- Appropriate Testing for Children with Pharyngitis (CWP) improved by 8.14 percentage points.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
  - BMI percentile – 3–11 Years improved by 6.56 percentage points.
  - BMI percentile – 12–17 Years improved by 15.33 percentage points.
  - BMI percentile – Total improved by 9.64 percentage points.
  - Counseling for Nutrition – 3–11 Years improved by 6.29 percentage points.
  - Counseling for Nutrition – 12–17 Years improved by 9.60 percentage points.
  - Counseling for Nutrition – Total improved by 7.52 percentage points.
  - Counseling for Physical Activity – 3–11 Years improved by 7.08 percentage points.
  - Counseling for Physical Activity – 12–17 Years improved by 9.39 percentage points.
  - Counseling for Physical Activity – Total improved by 8.00 percentage points.

Decreases in performance from MY 2016 to MY 2017:

- Follow-up After Hospitalization for Mental Illness (FUH)
  - 30-Day Follow-up decreased by 10.82 percentage points.
  - 7-Day Follow-up decreased by 17.44 percentage points.

Table 7: 2018 HEDIS Performance Measures

HEDIS 2018 Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Childhood Immunization (CIS)[1]					
Combination 2	58.39%	70.07%	55.96%	66.91%	54.74%
Combination 3	52.55%	64.96%	51.34%	60.83%	49.88%
Combination 9	27.49%	36.74%	28.47%	33.09%	24.33%
Lead Screening in Children (LSC)	59.61%	74.45%	74.45%	77.39%	74.45%
Well-Child Visits in the First 15 Months of Life – 6 or More Visits (W15)	48.19%	64.72%	62.29%	66.33%	58.92%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)[2]	68.86%	80.78%	77.42%	82.87%	82.99%
Adolescent Well-Care Visits (AWC)[2]	44.77%	63.59%	59.67%	60.42%	59.75%
Breast Cancer Screening (BCS)	36.34%	52.27%	58.79%	61.11%	58.54%
Cervical Cancer Screening (CCS)	31.14%	59.37%	58.64%	63.42%	50.85%
Comprehensive Diabetes Care (CDC)					
HbA1c Testing[1]	81.06%	84.87%	82.89%	86.62%	88.24%
HbA1c Poor Control (>9.0%)[1,3]	44.26%	34.78%	48.22%	33.82%	32.59%
HbA1c Control (<8.0%)[1]	45.72%	55.13%	44.44%	56.62%	58.47%
HbA1c Control (<7.0%) for a Selected Population[1]	30.41%	43.55%	34.63%	40.14%	44.89%
Eye Exam	32.42%	57.04%	59.18%	59.56%	57.53%
Medical Attention for Nephropathy	88.71%	90.09%	91.98%	90.59%	93.06%
Blood Pressure Controlled <140/90 mm Hg[1]	54.28%	60.52%	NR	67.94%	56.47%
Controlling High Blood Pressure (CBP)[1]	47.93%	59.61%	NR	67.65%	51.58%
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	80.45%	87.10%	74.70%	88.03%	83.29%
Postpartum Care	60.91%	66.42%	59.37%	66.22%	60.10%
Immunizations For Adolescents (IMA)					
Meningococcal	72.97%	87.59%	89.54%	87.59%	78.35%
Tdap/Td	82.43%	93.92%	93.19%	91.73%	89.78%
HPV	23.65%	25.79%	34.55%	27.25%	33.82%
Combination 1	72.30%	86.37%	87.35%	85.89%	77.13%
Combination 2	22.30%	24.33%	30.41%	25.55%	29.20%
Appropriate testing for children with pharyngitis (CWP)	80.19%	90.53%	67.61%	85.76%	76.68%
Chlamydia Screening (CHL)					
16-20 Years	59.68%	62.00%	56.50%	59.65%	59.45%
21-24 Years	64.20%	69.95%	68.14%	64.73%	64.99%
Total	62.24%	65.51%	61.53%	61.90%	62.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)[1]					
BMI percentile - 3-11 Years	77.82%	85.77%	63.06%	74.90%	70.34%
BMI percentile - 12-17 Years	72.73%	84.77%	63.64%	83.46%	75.68%
BMI percentile - Total	75.91%	85.40%	63.26%	77.86%	72.26%
Counseling for Nutrition - 3-11 Years	75.10%	84.23%	53.73%	70.52%	70.34%
Counseling for Nutrition - 12-17 Years	74.03%	80.79%	52.45%	77.44%	68.92%
Counseling for Nutrition - Total	74.70%	82.97%	53.28%	72.92%	69.83%
Counseling for Physical Activity - 3-11 Years	66.54%	76.54%	39.93%	61.75%	51.71%
Counseling for Physical Activity - 12-17 Years	72.08%	76.82%	39.16%	75.19%	60.14%
Counseling for Physical Activity - Total	68.61%	76.64%	39.66%	66.41%	54.74%
Follow up care for children prescribed ADHD medication (ADD)					

HEDIS 2018 Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Initiation Phase	N/A	34.97%	30.43%	38.19%	34.38%
Continuation and Maintenance Phase	N/A	40.74%	32.60%	39.73%	N/A
Follow-up after hospitalization for mental illness (FUH)[4]					
30-Day Follow-up	N/A	43.48%	31.90%	30.30%	40.38%
7-Day Follow-up	N/A	17.39%	15.24%	15.43%	17.31%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[4]					
30-Day Follow-up	38.95%	66.67%	48.39%	64.99%	60.00%
7-Day Follow-up	29.47%	54.55%	34.48%	52.76%	47.27%
Adult BMI Assessment (ABA)[1]	76.40%	92.70%	43.02%	92.45%	87.93%
Annual Monitoring for Patients on Persistent Medications (MPM)					
ACE Inhibitors or ARBs	84.22%	89.90%	89.25%	91.23%	92.64%
Diuretics	83.42%	88.51%	88.52%	90.59%	91.63%
Total	83.91%	89.36%	88.96%	90.98%	92.26%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
12-24 months	90.79%	95.91%	97.23%	97.88%	95.69%
25 months - 6 years	84.33%	91.39%	93.32%	93.46%	91.77%
7-11 years	81.78%	94.04%	96.18%	95.92%	96.33%
12-19 years	76.88%	91.06%	93.97%	93.79%	93.33%
Medication Management for People With Asthma (MMA)					
5-11 Years - 50% Compliance	N/A	53.77%	48.62%	50.65%	57.14%
12-18 Years - 50% Compliance	N/A	51.61%	46.08%	52.77%	43.59%
19-50 Years - 50% Compliance	N/A	60.91%	59.01%	65.50%	68.14%
51-64 Years - 50% Compliance	N/A	75.10%	72.86%	78.13%	76.19%
Total - 50% Compliance	58.06%	59.17%	55.33%	59.65%	66.22%
5-11 Years - 75% Compliance	N/A	28.71%	26.12%	25.40%	23.81%
12-18 Years - 75% Compliance	N/A	25.48%	24.77%	30.33%	28.21%
19-50 Years - 75% Compliance	N/A	37.65%	36.20%	41.87%	43.36%
51-64 Years - 75% Compliance	N/A	48.96%	48.16%	55.78%	55.24%
Total - 75% Compliance	35.48%	34.23%	32.65%	35.96%	42.81%
Annual Dental Visit (ADV)					
2-3 Years	35.06%	42.81%	50.48%	48.79%	50.33%
4-6 Years	49.51%	61.18%	70.24%	72.09%	66.02%
7-10 Years	54.09%	65.27%	73.83%	75.62%	71.28%
11-14 Years	46.76%	62.72%	71.61%	72.21%	68.50%
15-18 Years	40.81%	54.07%	63.61%	62.47%	58.18%
19-20 Years	34.30%	36.22%	48.78%	48.03%	40.31%
Total	44.91%	57.52%	66.89%	67.31%	62.98%
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)[5]					
Total - <1 Years	643.62	781.54	824.23	882.37	751.13
Total - 1-9 Years	280.66	346.88	362.49	393.68	378.80
Total - 10-19 Years	171.44	259.65	269.01	279.03	316.78
Total - 20-44 Years	193.47	278.31	357.94	358.68	354.43
Total - 45-64 Years	342.55	515.89	620.62	575.93	708.94
Total - 65-74 Years	490.42	733.74	673.21	410.79	1030.23
Total - 75-84 Years	449.09	578.91	650.65	438.36	1016.90
Total - 85+ Years	402.27	460.36	648.82	395.60	949.58

HEDIS 2018 Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Total - Unknown Years	N/A	N/A	N/A	N/A	N/A
Total - Total Years	258.59	350.98	394.89	398.99	478.53
Dual Eligibles - <1 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 1-9 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 10-19 Years	N/A	N/A	1500.00	0.00	N/A
Dual Eligibles - 20-44 Years	341.32	117.65	158.54	168.66	792.45
Dual Eligibles - 45-64 Years	776.79	400.00	622.95	292.30	1263.69
Dual Eligibles - 65-74 Years	423.38	N/A	891.19	311.50	1290.70
Dual Eligibles - 75-84 Years	610.53	450.00	1304.96	329.78	1376.13
Dual Eligibles - 85+ Years	410.26	N/A	1292.60	293.39	1332.70
Dual Eligibles - Unknown Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - Total Years	536.04	377.25	1025.56	296.64	1281.70
Disabled - <1 Years	750.00	891.50	307.69	1129.19	1056.82
Disabled - 1-9 Years	298.53	451.66	600.34	512.85	524.04
Disabled - 10-19 Years	165.46	256.26	425.23	323.85	387.64
Disabled - 20-44 Years	310.87	309.55	387.87	381.97	720.82
Disabled - 45-64 Years	750.46	767.67	879.14	860.24	1287.08
Disabled - 65-74 Years	502.17	738.65	1166.67	689.65	1015.21
Disabled - 75-84 Years	410.68	579.28	1090.91	670.09	922.74
Disabled - 85+ Years	414.29	460.36	N/A	540.90	951.20
Disabled - Unknown Years	N/A	N/A	N/A	N/A	N/A
Disabled - Total Years	481.54	515.42	458.51	579.61	993.12
Other Low Income - <1 Years	642.62	780.59	824.26	880.13	749.28
Other Low Income - 1-9 Years	280.31	344.15	361.90	390.39	376.02
Other Low Income - 10-19 Years	171.65	259.83	267.54	276.72	313.99
Other Low Income - 20-44 Years	190.40	275.72	357.52	358.91	331.23
Other Low Income - 45-64 Years	309.23	467.95	619.65	543.04	587.47
Other Low Income - 65-74 Years	880.95	469.27	669.86	542.37	69.98
Other Low Income - 75-84 Years	N/A	N/A	634.95	N/A	0.00
Other Low Income - 85+ Years	0.00	N/A	576.66	0.00	0.00
Other Low Income - Unknown Years	N/A	N/A	N/A	N/A	N/A
Other Low Income - Total Years	246.24	336.84	394.23	388.71	405.38
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)[5]					
Total - <1 Years	85.65	90.06	108.34	75.14	94.91
Total - 1-9 Years	50.03	46.26	55.06	40.43	49.07
Total - 10-19 Years	34.44	35.28	43.22	34.13	35.46
Total - 20-44 Years	68.48	70.28	92.19	66.40	77.89
Total - 45-64 Years	55.12	61.32	73.24	57.98	62.68
Total - 65-74 Years	28.62	36.74	33.24	23.66	47.71
Total - 75-84 Years	27.65	28.10	31.23	21.19	45.89
Total - 85+ Years	31.82	20.64	38.97	23.03	47.36
Total - Unknown Years	N/A	N/A	N/A	N/A	N/A
Total - Total Years	57.36	55.05	66.76	49.35	60.05
Dual Eligibles - <1 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 1-9 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 10-19 Years	N/A	N/A	250.00	0.00	N/A

HEDIS 2018 Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Dual Eligibles - 20-44 Years	65.87	58.82	79.27	40.29	227.59
Dual Eligibles - 45-64 Years	55.80	176.92	65.57	36.12	170.08
Dual Eligibles - 65-74 Years	27.27	N/A	28.50	21.69	77.57
Dual Eligibles - 75-84 Years	49.12	100.00	92.20	18.57	65.62
Dual Eligibles - 85+ Years	12.82	N/A	61.10	19.34	76.34
Dual Eligibles - Unknown Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - Total Years	41.19	155.69	66.13	26.38	102.93
Disabled - <1 Years	141.67	97.65	76.92	134.77	113.64
Disabled - 1-9 Years	55.22	58.86	62.98	74.58	86.45
Disabled - 10-19 Years	36.10	47.71	48.04	55.61	83.33
Disabled - 20-44 Years	150.24	93.26	77.25	97.37	184.06
Disabled - 45-64 Years	119.20	117.15	143.17	116.25	134.63
Disabled - 65-74 Years	29.03	37.11	62.50	29.18	31.17
Disabled - 75-84 Years	22.54	27.90	454.55	26.78	38.63
Disabled - 85+ Years	37.14	20.64	N/A	28.28	38.15
Disabled - Unknown Years	N/A	N/A	N/A	N/A	N/A
Disabled - Total Years	86.27	85.31	72.42	86.19	113.51
Other Low Income - <1 Years	85.12	90.00	108.34	74.60	94.79
Other Low Income - 1-9 Years	49.93	45.93	55.04	39.49	48.36
Other Low Income - 10-19 Years	34.38	34.61	43.17	33.02	33.58
Other Low Income - 20-44 Years	66.47	68.38	92.40	64.46	71.05
Other Low Income - 45-64 Years	50.34	50.63	72.98	49.16	46.49
Other Low Income - 65-74 Years	23.81	16.76	33.25	26.63	1.96
Other Low Income - 75-84 Years	N/A	N/A	29.42	N/A	0.00
Other Low Income - 85+ Years	0.00	N/A	36.49	0.00	0.00
Other Low Income - Unknown Years	N/A	N/A	N/A	N/A	N/A
Other Low Income - Total Years	56.03	52.44	66.71	47.32	53.63
Use of Opioids at High Dosage (UOD)[5]					
Eligible Population	122.62	119.23	104.97	107.77	97.80
Use of Opioids From Multiple Providers (UOP)[5]					
Multiple Prescribers	150.81	186.59	NR	140.96	141.26
Multiple Pharmacies	41.76	35.54	NR	34.17	49.65
Multiple Prescribers and Multiple Pharmacies	30.16	17.77	NR	16.89	26.57
Plan All-Cause Readmissions (PCR)[5]					
1-3 Index Stays per Year - 18-44	7.41%	6.44%	7.23%	7.05%	8.55%
1-3 Index Stays per Year - 45-54	3.37%	7.21%	8.60%	8.89%	8.68%
1-3 Index Stays per Year - 55-64	8.66%	10.30%	8.81%	9.68%	11.71%
1-3 Index Stays per Year - Total	6.88%	7.95%	8.09%	8.44%	9.80%
Observed-to-Expected Ratio	0.48	0.48	0.50	0.54	0.58
4+ Index Stays per Year - 18-44	N/A	59.22%	51.58%	54.99%	66.90%
4+ Index Stays per Year - 45-54	N/A	46.19%	46.85%	47.93%	51.35%
4+ Index Stays per Year - 55-64	46.88%	49.28%	44.35%	51.03%	43.20%
4+ Index Stays per Year - Total	50.00%	52.73%	48.03%	51.74%	54.84%
Observed-to-Expected Ratio	1.73	1.34	1.25	1.35	1.25
Total Index Stays per Year - 18-44	9.14%	16.65%	14.93%	14.47%	24.24%
Total Index Stays per Year - 45-54	13.46%	14.12%	14.84%	14.52%	16.01%

HEDIS 2018 Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Total Index Stays per Year - 55-64	16.35%	16.39%	15.29%	16.28%	18.43%
Total Index Stays per Year - Total	12.79%	15.87%	15.02%	15.08%	19.74%
Observed-to-Expected Ratio	0.78	0.77	0.75	0.79	0.86
Asthma Medication Ratio (AMR)					
5-11 Years	N/A	71.22%	72.84%	70.86%	53.45%
12-18 Years	N/A	59.64%	60.79%	63.18%	65.12%
19-50 Years	40.43%	43.68%	53.91%	50.87%	50.00%
51-64 Years	N/A	47.53%	56.09%	54.84%	62.99%
Total	45.05%	54.92%	60.80%	60.05%	56.68%
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
20-44 Years	53.65%	70.34%	79.66%	77.91%	66.64%
45-64 Years	66.78%	79.94%	87.93%	85.85%	81.60%
65+ Years	72.66%	85.06%	89.34%	94.67%	92.49%
Total	58.96%	74.33%	83.08%	81.80%	75.23%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[3,6]					
1 - 5 Years	NR	N/A	0.00%	N/A	N/A
6 - 11 Years	NR	2.10%	2.22%	0.55%	N/A
12 - 17 Years	NR	3.13%	4.39%	3.00%	4.35%
Total	NR	2.78%	3.52%	2.13%	3.08%

[1] Horizon did not complete the medical record review for all hybrid measures for HEDIS 2018, resulting in potential bias for five hybrid measures: ABA, CBP, WCC, CIS and CDC (Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), HbA1c Control (<7.0%), and Blood Pressure Controlled <140/90 mm Hg) for a Selected Population. These measures demonstrated potential bias greater than or equal to 10%, therefore were excluded from the state weighted and unweighted averages.
[2] W34 and AWC were calculated administratively by HNJH in HEDIS 2018, the other four plans reported via hybrid.
[3] Higher rates for HbA1c Poor Control and APC indicate poorer performance.
[4] Follow-up After Hospitalization and Follow-up After Emergency Department Visit for Mental Illness are limited to the DDD population and the MLTSS population.
[5] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance. UOP and UOD are new measures this year; it's calculated per 1,000 members (millage). PCR is also a new measure. 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.
[6] ABHNJ noted not enough population was reported in HEDIS 2018.
Designation N/A: For non-ambulatory measures, indicates that MCO had a denominator less than 30. For ambulatory measures, indicates that the plan had 0 member months in the denominator.
Designation NR: Indicates that MCO did not report for the measure.

HNJH had significant difficulty in reporting hybrid HEDIS measures. HNJH received a “not reported” (NR) determination due to biased rate (BR) for the Use of Opioids from Multiple Providers (UOP) measure, which resulted from an issue with correctly identifying pharmacy providers (**Table 7**). The plan also received an NR/BR for the CDC Blood Pressure measure and the Controlling High Blood Pressure measure (**Table 7**). The difficulties with the hybrid measures originated from problems that the auditor noted in identification of the correct populations to report HEDIS rates. This resulted in a delay in starting the medical record retrieval.

At the direction of the State, HNJH undertook completion of the medical record pursuits. This process was reviewed by IPRO and the revised hybrid measures were validated by one of IPRO’s certified HEDIS auditors (CHCAs). A revised set of measures was submitted to the State. In addition to the hybrid measures, HNJH restated the UOP measure. The revised audit review table (ART) is presented in **Appendix: January 2018–December 2018 MCO-Specific Review Findings** following the ART that was submitted to NCQA during the HEDIS audit process.

2018 New Jersey State-Specific Measures and Core Set Measures

2018 New Jersey State-Specific Measures

As more patients with disabilities and chronic conditions transition to managed care from Fee-for-Service (FFS), three performance measures were developed by IPRO, in conjunction with DMAHS. Two of these measures are HEDIS measures – AAP and CAP – that are reported for the Dual Eligibles, Disabled and Other Low Income subpopulations. The intent of these breakouts is to assist in identifying areas in need of improvement for reducing disparities in care. The third measure, also reported at the total and subpopulation level, is Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit). This is a custom measure.

2018 New Jersey Core Set Measures

Developmental Screening in The First Three Years of Life (Developmental Screening) was added to MY 2017 and is defined by age groups: 1 year old, 2 year old, and 3 year old.

All MCOs reported the required NJ state-specific measures and core set measures for MY 2017. All plans were required to report all Dual Eligibles for the NJ Preventive Dental Visit measure. The following should be considered for valid interpretation and comparison of reported rates. AGNJ did not include their FIDE SNP members in the HEDIS submission due to NCQA accreditation. A smaller eligible population was reported by WCHP for NJ-specific measures compared to the HEDIS AAP and ADV measures, due to incarceration capitation codes not being included when the specifications for the NJ-specific measures were developed (**Table 8**).

Table 8: 2018 New Jersey State-Specific Performance Measures

NJ Specific Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total Medicaid - 20-44 years	53.65%	70.34%	79.66%	77.91%	66.64%
Total Medicaid - 45-64 years	66.78%	79.94%	87.93%	85.85%	81.60%
Total Medicaid - 65+ years	72.66%	85.06%	89.34%	94.67%	92.49%
Total Medicaid - Total	58.96%	74.33%	83.08%	81.80%	75.23%
Dual Eligibles - 20-44 years	N/A	N/A	79.55%	93.11%	94.87%
Dual Eligibles - 45-64 years	N/A	N/A	91.53%	97.41%	97.81%
Dual Eligibles - 65+ years	66.04%	N/A	94.90%	97.91%	98.06%
Dual Eligibles - Total	68.92%	N/A	91.97%	97.39%	97.82%
Disabled - 20-44 years	62.36%	68.62%	85.17%	78.10%	79.24%
Disabled - 45-64 years	82.40%	87.60%	93.54%	91.65%	90.70%
Disabled - 65+ years	74.63%	85.24%	89.20%	87.90%	89.60%
Disabled - Total	74.46%	79.71%	90.25%	86.01%	87.48%
Other Low Income - 20-44 years	53.35%	70.55%	79.14%	77.75%	65.18%
Other Low Income - 45-64 years	65.26%	78.09%	86.41%	83.99%	79.09%
Other Low Income - 65+ years	N/A	N/A	81.97%	82.35%	N/A
Other Low Income - Total	57.63%	73.32%	81.79%	79.98%	71.45%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Total Medicaid - 12-24 months	90.79%	95.91%	97.23%	97.88%	95.69%
Total Medicaid - 25 months - 6 years	84.33%	91.39%	93.32%	93.46%	91.77%
Total Medicaid - 7-11 years	81.78%	94.04%	96.18%	95.92%	96.33%
Total Medicaid - 12-19 years	76.88%	91.06%	93.97%	93.79%	93.33%
Total Medicaid - 12 months -19 years	83.43%	92.23%	94.58%	94.52%	93.71%
Dual Eligibles - 12-24 months	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 25 months - 6 years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 7-11 years	N/A	N/A	N/A	N/A	N/A

NJ Specific Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Dual Eligibles - 12-19 years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - Total - 12 months -19 years	N/A	N/A	N/A	N/A	N/A
Disabled - 12-24 months	N/A	82.93%	93.33%	92.59%	N/A
Disabled - 25 months - 6 years	83.87%	88.52%	94.35%	94.08%	90.63%
Disabled - 7-11 years	N/A	93.57%	97.41%	95.68%	98.10%
Disabled - 12-19 years	N/A	86.64%	93.32%	92.63%	94.33%
Disabled - Total - 12 months -19 years	85.90%	88.79%	94.77%	93.82%	94.82%
Other Low Income - 12-24 months	90.61%	96.06%	97.29%	97.96%	95.67%
Other Low Income - 25 months - 6 years	84.34%	91.46%	93.29%	93.45%	91.80%
Other Low Income - 7-11 years	81.51%	94.06%	96.12%	95.93%	96.26%
Other Low Income - 12-19 years	76.76%	91.34%	94.01%	93.86%	93.27%
Other Low Income - Total - 12 months -19 years	83.37%	92.37%	94.57%	94.55%	93.67%
Preventive Dental Visit					
Total - 2-3 Years	27.10%	42.12%	49.85%	47.79%	50.23%
Total - 4-6 Years	35.11%	59.40%	68.49%	69.93%	64.91%
Total - 7-10 Years	34.52%	63.02%	71.78%	73.05%	69.03%
Total - 11-14 Years	30.37%	59.47%	68.27%	68.59%	65.02%
Total - 15-18 Years	24.30%	49.12%	58.40%	57.53%	53.16%
Total - 19-21 Years	14.94%	32.19%	42.79%	41.82%	32.01%
Total - 22-34 Years	16.50%	26.64%	37.88%	36.33%	28.11%
Total - 35-64 Years	18.46%	28.29%	37.72%	36.38%	32.92%
Total - 65+ Years	21.46%	30.07%	29.08%	26.93%	29.96%
Total - Total	21.63%	40.78%	50.52%	49.71%	40.01%
Dual Eligibles - 2-3 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 4-6 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 7-10 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 11-14 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 15-18 Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - 19-21 Years	N/A	N/A	38.24%	43.94%	N/A
Dual Eligibles - 22-34 Years	18.37%	35.47%	37.67%	38.02%	34.29%
Dual Eligibles - 35-64 Years	18.34%	34.01%	40.05%	39.45%	37.87%
Dual Eligibles - 65+ Years	21.75%	31.85%	29.67%	27.49%	30.84%
Dual Eligibles - Total	20.83%	32.43%	33.70%	31.79%	32.24%
Disabled - 2-3 Years	N/A	37.50%	45.60%	44.31%	N/A
Disabled - 4-6 Years	N/A	48.97%	58.26%	56.06%	44.00%
Disabled - 7-10 Years	22.50%	48.57%	61.92%	59.71%	44.79%
Disabled - 11-14 Years	28.21%	44.94%	58.02%	57.64%	47.15%
Disabled - 15-18 Years	8.62%	38.96%	51.98%	46.29%	39.20%
Disabled - 19-21 Years	7.75%	23.80%	38.05%	32.81%	23.08%
Disabled - 22-34 Years	12.00%	23.95%	36.51%	32.42%	31.60%
Disabled - 35-64 Years	19.34%	24.91%	31.36%	30.64%	30.60%
Disabled - 65+ Years	17.02%	18.23%	23.55%	22.44%	22.37%
Disabled - Total	15.54%	27.70%	38.08%	35.93%	29.91%
Other Low Income - 2-3 Years	27.13%	42.19%	49.92%	47.85%	50.47%
Other Low Income - 4-6 Years	35.74%	59.69%	68.83%	70.40%	65.44%
Other Low Income - 7-10 Years	35.10%	63.61%	72.23%	73.60%	69.91%

NJ Specific Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Other Low Income - 11-14 Years	30.48%	60.14%	68.83%	69.14%	65.91%
Other Low Income - 15-18 Years	25.76%	49.72%	58.78%	58.19%	53.93%
Other Low Income - 19-21 Years	17.17%	33.57%	43.26%	43.00%	33.33%
Other Low Income - 22-34 Years	16.64%	26.84%	38.03%	36.69%	27.39%
Other Low Income - 35-64 Years	18.41%	28.40%	38.60%	36.77%	32.39%
Other Low Income - 65+ Years	N/A	N/A	34.52%	30.79%	N/A
Other Low Income - Total	22.25%	43.09%	53.93%	53.48%	44.40%
Developmental Screening[1]					
1 year old	30.94%	34.22%	31.06%	20.69%	27.75%
2 year old	31.91%	47.64%	41.12%	36.36%	28.24%
3 year old	25.00%	41.74%	35.45%	32.85%	24.45%
Total - 1-3 year	29.90%	41.70%	36.21%	31.42%	26.72%

[1] Developmental screening is a new measure for measurement year 2017.
Designation N/A: Indicates that MCO had a denominator of 0.

2018 MLTSS Performance Measure Validation

During July 1, 2016–June 30, 2017, IPRO worked closely with DMAHS Office of MLTSS Quality Monitoring and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications for the July 2017–June 2018 measurement period were developed for the following PMs:

PM #4: Timeliness of NF Level of Care Assessment by MCO
Assesses the timeliness of assessments following a referral of an MCO member for MLTSS services. Reported monthly.

PM #18: Critical Incident Reporting
Assesses the reporting of Critical Incidents by the MCO to the State by category within the reporting period. Reported quarterly and annually.

PM #20: MLTSS Members Receiving MLTSS Services
Assesses the number of unique MLTSS members receiving MLTSS services during the measurement period. Reported quarterly and annually.

PM #21: MLTSS Members Transitioned from NF to Community
Assesses the number NF MLTSS eligible members transitioning to HCBS during the measurement period. Reported quarterly and annually.

PM #22: New NF Living Arrangement for MLTSS Members
Assesses the number of new MLTSS eligible members with an NF living arrangement status at any time during the reporting year. Reported annually.

PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days
Assesses the number of MLTSS eligible members who transitioned from NF to HCBS during the reporting period and returned to NF status within 90 days of the transition to HCBS. Reported quarterly and annually.

PM #24: MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days
Assesses the number of HCBS MLTSS eligible members who transitioned from HCBS to NF during the reporting period for more than 180 days. Reported quarterly and annually.

PM #25: MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less
Assesses the number of HCBS MLTSS eligible members who transitioned from HCBS to NF during the reporting period for 180 days or less. Reported quarterly and annually.

PMs #26 and #27: Acute Inpatient Utilization by MLTSS Members
Summarizes utilization of acute inpatient (IP) visits for MLTSS members. Two rates are reported: PM#26 summarizes IP utilization for HCBS members, and PM #27 summarizes IP utilization for NF members. Reported quarterly and annually.

PM #28: Readmissions of MLTSS HCBS Members to Hospital within 30 Days
Assesses the number of acute inpatient stays during the measurement period for MLTSS HCBS members that were followed by an acute inpatient readmission within 30 days of the Index Discharge Date. Reported quarterly and annually.

PM #29: Readmissions of MLTSS NF Members to Hospital within 30 Days
Assesses the number of acute inpatient stays during the measurement period for MLTSS NF members that were followed by an acute inpatient readmission within 30 days of the Index Discharge Date. Reported quarterly and annually.

PMs #30 and #31: ER Utilization by MLTSS Members
Summarizes utilization of Emergency Room (ER) visits for MLTSS members. Two rates are reported: PM #30 summarizes ER utilization for HCBS members, and PM #31 summarizes IP utilization for NF members. Reported quarterly and annually.

PMs #33, #34 and #41: MLTSS Services Used by HCBS Members
Assesses the percent of unique HCBS members using: PCA Services only (PM #33), Medical Day Services only (PM #34), and PCA Services and Medical Day Services Only (PM #41). Reported quarterly and annually.

PM #36: Follow-up After Mental Health Hospitalization for HCBS MLTSS Members
Assesses the percentage of discharges for eligible MLTSS HCBS members who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 30 days of discharge. Reported quarterly and annually.

PM #38: Follow-up After Mental Health Hospitalization for NF Members
Assesses the percentage of discharges for eligible MLTSS NF members who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 30 days of discharge. Reported quarterly and annually.

PMs #39 and #40: MLTSS Members with Select Behavioral Health Diagnoses
Assesses the percentage of unique MLTSS members with a behavioral health diagnosis during measurement period. Two rates are reported: PM #39 assesses the percentage of HCBS members with a behavioral health diagnosis, and PM #40 assesses the percentage of NF members with a behavioral health diagnosis. Reported quarterly and annually.

PMs #42 Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for HCBS MLTSS Members; and #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for NF MLTSS Members
Assesses the percentage of Emergency Department (ED) visits for MLTSS HCBS and NF members with a principal diagnosis of Alcohol or Other Drug (AOD) dependence and who had a follow-up visit for AOD within 30 days of the ED visit. Reported quarterly and annually.

PMs #44: Follow-up After Emergency Department Visit for Mental Illness for HCBS MLTSS Members; and #45: Follow-up After Emergency Department Visit for Mental Illness for NF MLTSS Members
Assesses the percentage of Emergency Department (ED) visits for MLTSS HCBS and NF members with a principal diagnosis of Mental Illness and who had a follow-up visit for Mental Illness within 30 days of the ED visit. Reported quarterly and annually.

The MCOs submitted source code (where applicable) and descriptions of their methodologies and source data for production of each performance measure. IPRO met with each MCO to review their submissions and to request modifications to submissions as necessary. Following validation, data were submitted to the NJ Office of MLTSS Quality Monitoring team for submission to CMS.

Measures requiring claims have an 8-month lag from the last date of the measurement period to the reporting period, allowing for a 6-month claim lag, 1-month period for report development and 1 month for reporting. The timeframe for the MY 2018 reports ran through February 2019, which is outside the scope of this report.

IPRO worked closely with DMAHS Office of MLTSS Quality Monitoring and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications for the July 2017–June 2018 measurement period were developed for the following PMs: #4: Timeliness of Nursing Facility (NF) Level of Care Assessment by MCO; #18: Critical Incident Reporting, #20: Total Number of MLTSS Members Receiving MLTSS Services; #21: MLTSS Members Transitioned from NF to Community; #22: New NF Living Arrangement for MLTSS Members; #23: NF to Home- and Community-Based Services (HCBS) Transitions who Returned to NF within 90 Days: #24: MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days; #25: MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less; #26 and #27: Acute Inpatient Utilization by MLTSS Members; #28: Readmissions of MLTSS HCBS Members to Hospital within 30 Days; #29: Readmissions of MLTSS NF Members to Hospital within 30 Days; #30 and #31: ER Utilization by MLTSS Members; #33, #34 and #41: MLTSS Services Used by MLTSS HCBS Members; #36: Follow-Up After Mental Health Hospitalization for MLTSS HCBS Members; #38: Follow-Up After Mental Health Hospitalization for NF Members; #39 and #40: MLTSS Members with Select Behavioral Health Diagnoses; #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS Members; #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS NF Members; #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members; and #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members.

Following the release of NCQA's *Rules for Allowable Adjustments of HEDIS 2019*, in the 4th quarter of 2018, IPRO worked with DMAHS to ensure that HEDIS-based measures followed the NCQA guidance. For the upcoming year, 2019 specifications directed the MCOs to produce the following measures following HEDIS methodology and reporting the unmodified HEDIS measure for the MLTSS subpopulations of interest:
#26, #27 – IPU (Inpatient Utilization—General Hospital/Acute Care)
#28, #29 – PCR (Plan All-Cause Readmissions)
#30, #31 – AMB (Ambulatory Care)
#36, #38 – FUH (Follow-up After Hospitalization for Mental Illness)
#42, #43 – FUA (Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence)
#44, #45 – FUM (Follow-up After Emergency Department Visit for Mental Illness)

2018 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the plan of care (POC). This measure ensures HCBS MLTSS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. In 2016, 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. In 2017, IPRO calculated PM #13, using POCs and claims data.

In July 1, 2016–June 30, 2017, IPRO undertook an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (blackout periods).

A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and blackout period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2016 and June 30, 2017.

Plan of Care Services Assessed

The list of MLTSS services assessed in this methodology is presented in **Table 9**. MLTSS services were identified in the MLTSS Service Dictionary. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services.

Table 9: MLTSS HCBS Services Assessed for Performance Measure #13

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

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

Performance Measure Methodology

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

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

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

A total of 103 records were excluded, resulting in a study population of 447 members across all plans (**Table 10**). Records could be excluded for a number of reasons, including: 1) no POC submitted in the file; 2) POCs submitted did not have the necessary information to produce quantifiable expected services; and 3) POCs only documented services that were not evaluated for this measure, such as respite care or behavioral health services.

Table 10: MLTSS Performance Measure #13 Study Population

MCO	Total Sampled	Total Excluded	Study Population
ABHNJ	110	38	72
AGNJ	110	19	91
HNJH	110	13	97
UHCCP	110	13	97
WCHP	110	20	90
Total	550	103	447

Table 11 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 32.4%. As noted above, compliance with PM #13 was based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery had to exceed 95% for each service documented in the POC for each member. Of the 447 total members in the denominator, 145 (32.4%) received, on average, 95% of the planned service amount for all services documented in the POC.

Table 11: MLTSS Performance Measure #13 Compliance Rates

MCO	Denominator	Numerator	Compliance Rate
ABHNJ	72	25	34.7%
AGNJ	91	34	37.4%
HNJH	97	31	32.0%
UHCCP	97	33	34.0%
WCHP	90	22	24.4%
Total	447	145	32.4%

Table 12 shows the services that were evaluated for this measure, and the proportion of those services that were above the 95% average service delivery threshold. The denominators displayed in **Table 12** are the number of members that had the indicated service documented in their plan of care 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 may have appeared in more than one service.

Compliance for PM #13, shown in **Table 11**, is achieved when the 95% threshold is met for all services planned for that member. **Table 12** shows the number of services where the average service delivery exceeded the 95% threshold. **Table 12** provides an analysis of expected delivery of services at the service level.

Across all plans, the most common MLTSS service was PCA/Home Based Supportive Care; of the 244 members who had PCA/HBSC services planned, 91 (37.3%) received, on average, 95% or more of the planned amount (**Table 12**). Of the MLTSS services listed, Assisted Living was associated with the highest proportion of members reaching the 95% average threshold; of the 85 members who had Assisted Living services planned, 66 (77.6%) received on average at least 95% of the planned amount.

Table 12: MLTSS Services At or Above the 95% Average Service Delivery Threshold

Services Evaluated	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			All MCOs		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Adult Family Care	0	0		0	0		0	0		0	0		0	0		0	0	
Assisted Living Services/Programs	9	7	77.8%[1]	21	17	81.0%	18	14	77.8%	36	28	77.8%	1	0	0.0%[1]	85	66	77.6%
Chore Services	0	0		0	0		0	0		1	0	0.0%[1]	0	0		1	0	0.0%[1]
Cognitive Therapy	0	0		1	0	0.0%[1]	3	0	0.0%[1]	0	0		0	0		4	0	0.0%[1]
Community Residential Services	0	0		1	0	0.0%[1]	1	1	100.0%[1]	0	0		0	0		2	1	50.0%[1]
Home Delivered Meals	27	8	29.6%	24	7	29.2%	32	12	37.5%	29	6	20.7%	23	7	30.4%	135	40	29.6%
Medical Day Services	5	0	0.0%[1]	13	2	15.4%	13	1	7.7%	11	1	9.1%	51	20	39.2%	93	24	25.8%
Non-Medical Transportation	0	0		1	0	0.0%[1]	0	0		1	0	0.0%[1]	0	0		2	0	0.0%[1]
Medication Dispensing Device Monthly Monitoring	1	0	0.0%[1]	0	0		0	0		0	0		0	0		1	0	0.0%[1]
Occupational Therapy	0	0		0	0		2	1	50.0%[1]	0	0		0	0		2	1	50.0%[1]
PCA/Home Based Supportive Care	50	28	56.0%	43	9	20.9%	56	23	41.1%	49	11	22.4%	46	20	43.5%	244	91	37.3%
PERS Monitoring	40	22	55.0%	49	38	77.6%	47	31	66.0%	28	15	53.6%	43	26	60.5%	207	132	63.8%
Physical Therapy	0	0		1	0	0.0%[1]	1	0	0.0%[1]	0	0		0	0		2	0	0.0%[1]
Private Duty Nursing	1	0	0.0%[1]	0	0		3	0	0.0%[1]	0	0		1	0	0.0%[1]	5	0	0.0%[1]
Social Adult Day Care	5	0	0.0%[1]	0	0		2	0	0.0%[1]	3	0	0.0%[1]	1	0	0.0%[1]	11	0	0.0%
Speech, Language and Hearing Therapy	0	0		0	0		2	0	0.0%[1]	0	0		0	0		2	0	0.0%[1]
Structured Day Program	0	0		1	0	0.0%[1]	1	0	0.0%[1]	0	0		0	0		2	0	0.0%[1]
Supported Day Services	0	0		0	0		0	0		0	0		0	0		0	0	
TBI Behavioral Management	0	0		0	0		0	0		0	0		0	0		0	0	

[1] Fewer than 10 members in the denominator; rates should be considered with caution.

Gray shading: no rate was calculated, because denominator was zero.

D: denominator; N: numerator, %: rate.

Conclusion and Recommendations
This is the second year that PM #13 has been produced through review of care management records. Comparison of care management records to claims is the recommended methodology for producing this PM.

The overall compliance rate for PM #13 was 32.4%, which was an improvement over the rate of 25.3% observed in the prior year. WCHP had the lowest compliance rate, with a rate of 24.4%. The highest compliance rate was achieved by AGNJ, with a rate of 37.4%. More eligible records were submitted by each of the MCOs compared to the prior year.

Recommendations:

- None of the MCOs achieved a compliance rate of 50%. The MCOs should establish a methodology to evaluate delivery of services in the POC in real time and should develop a process to ensure that services listed in the POC are delivered in a manner consistent with the member needs identified in the POC.
- Claims were often submitted with a) duplicates with same span and service from multiple claim records; b) incorrect unit for services; c) unreasonable amount of rendered services; and/or d) missing procedure codes. The MCOs should review claims prior to submission to ensure that the file received correctly reflects the services rendered.
- A significant portion of members were excluded due to having no POC submitted in the file: 86 (15.6%) out of the 550 members in the sample. The MCOs should continually monitor care management files to ensure that POCs are complete and accurate. In future calculations of PM #13, it is recommended that MCOs provide a written rationale for each case lacking a POC or lacking a POC with the services evaluated for PM #13.
- The MCOs should ensure that the POCs are signed to meet contractual requirements.

Core Medicaid/MLTSS Performance Improvement Projects

Performance improvement projects (PIPs) are studies that MCOs conduct to evaluate and improve processes of care based on identified barriers. PIPs should follow rigorous methodology that will allow for the identification of interventions that have been proven to improve care. Ideally PIPs are cyclical in that they test for change on a small scale, learn from each test, refine the change based on lessons learned, and implement the change on a broader scale, for example, spreading successes to the entire MCO's population. Periodic remeasurement should be undertaken to continually evaluate the effectiveness of the interventions implemented and to ensure that the gains have been sustained over time.

For January 2018-December 2018, this QTR includes IPRO's evaluation of the April 2018 and August 2018 PIP report submissions and Fall 2018 PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols.

In 2018, WCHP submitted a final PIP pertaining to "Obesity in Adolescents." Additionally, WCHP, HNJH and UHCCP submitted their final PIP on "Preterm Birth Rates," and AGNJ submitted progress reports for this PIP. Likewise, all MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) submitted progress reports for their PIPs relating to EI. In September 2018, ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted proposals for a new PIP titled, "MCO Adolescent Risk Behaviors and Depression Collaborative." In 2018, all MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) continued to submit progress reports for PIPs relating to fall prevention for the MLTSS population. In October 2018, AGNJ submitted a PIP proposal for their new MLTSS Falls PIP. In December 2018, all MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) submitted proposals for a new PIP titled, "MLTSS Gaps in Care."

The MCOs participated in a collaborative PIP initiated in the fall of 2018 titled, "MCO Adolescent Risk Behaviors and Depression Collaborative." IPRO's role was to arrange and facilitate an introductory meeting with the MCOs to orient them to the topic, to establish the standardized metrics, and, for each MCO, to determine the lead collaborator and point of contact for the project. Following the introductory meeting, IPRO will attend subsequent meetings. These meetings are regularly scheduled and chaired by the MCOs. IPRO provided guidance and final approval for the collaborative aim and standardized metrics. IPRO will validate the data abstraction tool developed by the MCOs. IPRO produced a report on the focused study of the collaborative project design and methodology, describing the

collaborative development process, the establishment of standardized metrics, and the performance outcomes, as well as the scope of the validation conducted by IPRO across the collaborative project.

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

Assessment Methodology

In accordance with article 4.6.2 (Q) – PIPs of the NJ FamilyCare Managed Care Contract, MCOs are required to design, implement, and report results for each study topic area defined by DMAHS. IPRO conducted a comprehensive evaluation of each MCO's PIPs to determine compliance with the CMS protocol, "Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Reviews (EQR)." IPRO assessed each PIP for compliance with the relevant review categories for that PIP's submission. The review categories are listed below:

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

In January 2018–December 2018, IPRO reviewed the reports and provided suggestions to the MCOs to enhance their studies. Each of the five MCOs submitted the following PIPs:

ABHNJ

PIP 1: Reduction of Falls Among Home- and Community-Based Members in MLTSS
PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children 0-3 years
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Reduction in ER and IP Utilization Through Enhanced Chronic Disease Management
In 2018, the MCO submitted progress reports for PIP 1 and PIP 2, and proposals for PIP 3 and PIP 4.

AGNJ

PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population
PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old
PIP 3: Reduction of Preterm Births – Increasing Progesterone Utilization Rates (ending project year 1 in 2016) and Reduction of the Amerigroup Preterm Birth Rate by 5% (re-working of original project, establishing new baseline year of 2016, MY 1 in 2017, MY 2 in 2018 and sustainability year of 2019)
PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)
PIP 6: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population (this is a new Falls PIP)
In 2018, the MCO submitted a final report for PIP 1 and, progress reports for PIP 1, PIP 2 and PIP 3, and proposals for PIP 4, PIP 5 and PIP 6.

HNJH

PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Supports (MLTSS) Members
PIP 2: Developmental Screening and Early Intervention in Young Children
PIP 3: Improving Early Identification of Pregnancy and Birth Outcomes
PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative

PIP 5: Reducing Admissions, Readmissions and Gaps in Services for Members with Congestive Heart Failure in the Horizon MLTSS Home and Community Based Setting Population
In 2018, the MCO submitted progress reports for PIP 1 and PIP 2, a final report for PIP 3, and proposals for PIP 4 and PIP 5.

UHCCP

PIP 1: Prevention of Recurrent Falls in MLTSS Members with History of Falls
PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)
PIP 3: Preterm Births in Hudson County, NJ
PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 5: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population
In 2018, the MCO submitted progress reports for PIP 1 and PIP 2, a final report for PIP 3, and proposals for PIP 4 and PIP 5.

WCHP

PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 years of Age and Older That Fall
PIP 2: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age
PIP 3: Reducing the Rate of Preterm Births in the NJ Medicaid Population
PIP 4: Improving the Identification & Management of Pediatric Obesity in the 12-17 Year-Old Medicaid Population
PIP 5: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 6: Improving Diabetes Self-Care Management Through Personal Care Support Services
In 2018, the MCO submitted progress reports for PIP 1 and PIP 2, final reports for PIP 3 and PIP 4, and proposals for PIP 5 and PIP 6.

In February 2018, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO presented the two new PIP templates that were scheduled to be initiated in April 2018. The training focused on the changes from the old PIP submission format to the new PIP templates. The template for April will require the MCOs to submit project updates through March, and the August submission will require the MCOs to submit a project status report based on the cycle of the PIP. Individual meetings with the MCOs were held as required to assist with the initial submission with the new templates.

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

Summary of PIP Performance

PIP Strengths

The "Preventing Recurrent Falls in MLTSS Members with History of Falls" PIP covered the intervention and sustainability period from January 1, 2016 to December 2018. A common strength was that the MCO interventions were relevant to the identified MCO barriers as well as to the common barriers identified by all MCOs.

All five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) had identified a population relevant to each MCO's project and contained strong rationale for their study. Interventions were identified based on continued barrier analysis. A new PIP proposal was introduced by all five MCOs who identified a relevant population for the Risk Behaviors and Depression among Adolescent in NJ Medicaid Managed Care PIP. In addition, a new PIP proposal was introduced by all five MCOs related to MLTSS gaps in care in Fall 2018.

Opportunities for Improvement

A common area noted for improvement across the Risk Behaviors and Depression Among Adolescents in NJ Medicaid Managed Care PIP proposals of all five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) related to study design and data collection procedures including, but not limited to, identifying appropriate data sources, developing a method of

collecting valid and reliable data and documenting a data analysis plan. IPRO reviewed these findings individually with each MCO to achieve improvement in these common areas.

In addition, continued improvement is needed regarding the relationship between barriers, interventions, intervention tracking measures and the evaluation of outcomes. IPRO also reviewed these findings with each MCO to achieve improvement.

DMAHS Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State encounter data unit 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 Encounter Data Monitoring Unit (EDMU) calls with the MCOs. In 2018, IPRO continues to monitor encounter data submissions and patterns.

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from DXC, formerly Molina. IPRO loads the following data to IPRO's SAS data warehouse: member eligibility, demographic and TPL information and State-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation and vision encounter data.

DMAHS is planning on migrating their encounter data Replacement Medicaid Management Information System (RMMIS) in the future. As of October 2017, IPRO has been attending EDMU's monthly "new RMMIS" calls with the MCOs, taking part in the discussions regarding the updated encounter data elements and information.

Focused Quality Studies

2018 Behavioral Health Transportation Focused Study

At the request of DMAHS, IPRO undertook a review of transportation services provided to the Medicaid beneficiaries accessing behavioral health services in New Jersey.

Two types of phone surveys were done for beneficiaries that had scheduled a trip with LogistiCare, the transportation provider. The first survey was for beneficiaries that had a completed trip. The purpose of this survey was to assess the beneficiary's satisfaction with the trip itself, and the beneficiary's satisfaction with LogistiCare. The second survey was for beneficiaries that had scheduled a trip, but the trip was canceled. The purpose of this survey was to determine the reasons for cancelations and to assess satisfaction with rescheduling the appointment.

Data Sources: Record Procurement and Review

LogistiCare provided IPRO with a daily file of all trips that were processed the previous day. From this file, IPRO selected a random sample of trips that were appropriate for each survey. Surveys were stratified by region. The three regions defined were North, Central and South New Jersey. As directed by DMAHS, the regional breakouts are as follows:

- North: Sussex, Warren, Passaic, Bergen, Morris, Essex and Hudson;
- Central: Hunterdon, Middlesex, Monmouth, Ocean, Somerset and Union; and
- South: Mercer, Camden, Burlington, Gloucester, Salem, Atlantic, Cape May and Cumberland.

Summary of Findings

A total of 326 phone calls were made to reach beneficiaries who had had a completed trip (from residence to appointment, sometimes referred to as an A-leg trip) within an average of 2.6 days from the trip according to LogistiCare records. Each number was called only once, and the result recorded as "beneficiary not reached," "declined to participate," or completed survey.

The first section of the survey was regarding the beneficiary's satisfaction with when they were picked up from their residence and dropped off at their appointment. The majority of the beneficiaries who were surveyed about

their completed trip were satisfied with the time the vehicle arrived to pick them up, with an 86.1% satisfaction rate in North New Jersey, 86.7% in Central New Jersey, 84.3% in South New Jersey, and 85.8% statewide. Out of 41 beneficiaries who were not satisfied with the pick-up time, 73.2% of the beneficiaries were late to the appointment.

Overall, 34.0% of beneficiaries indicated that the driver made additional stops after picking them up to pick up or drop off other beneficiaries during their trip. Regional rates ranged from 30.7% in North New Jersey to 38.8% in Central New Jersey. Of the 98 beneficiaries who indicated that the driver made additional stops, 51 (52.0%) beneficiaries indicated that there was one additional stop, 38 (38.8%) beneficiaries had two stops, 3 (3.1%) beneficiaries had three stops, and 5 (5.1%) indicated that the driver made four or more stops after picking them up. It should be noted that the numbers of three and four or more stops are very low and should be regarded with caution. As expected, there was a general downward trend in the number of trips with more stops. Out of the beneficiaries who experienced additional stops during their trips, 20.4% considered it inconvenient. Half (50.0%) of the beneficiaries who considered additional stops inconvenient were late to the appointment.

Beneficiaries can arrange with LogistiCare for their trip back home from their appointment. These trips can either be scheduled ahead of time (referred to as "prescheduled") or the beneficiary or facility can call LogistiCare after the beneficiary's appointment for a pick-up (referred to as "will call"). Of the 288 beneficiaries who had a completed A-leg (from home to appointment) trip, 260 (90.3%) also had a trip back home using LogistiCare services. Of these 260 beneficiaries who used LogistiCare services for their trip back home, 239 (91.9%) beneficiaries prescheduled their trip, while 20 (7.7%) beneficiaries called LogistiCare after their appointment for a pick-up. For the beneficiaries who prescheduled the return trip and completed their appointment before the pick-up time, 81.2% of the vehicles arrived on time for pick up.

Beneficiaries can directly call LogistiCare to schedule the transportation. Of the 288 beneficiaries who completed the survey, 231 (80.2%) beneficiaries contacted LogistiCare directly for the service. Regionally, satisfaction rates with LogistiCare contact (very good/good) ranged from 85.4% for North and Central New Jersey to 89.6% for South New Jersey.

The second phone survey was for beneficiaries who had a trip scheduled, but the trip was canceled. The primary objective of this survey was to determine the reason for cancellations as reported by the beneficiaries. The secondary objective was to assess the beneficiaries' satisfaction with LogistiCare assistance in rescheduling missed appointments.

A total of 156 phone calls were made to reach beneficiaries who had had a cancelled trip within an average of 6.3 days from the cancellation according to LogistiCare records. Each number was called only once, and the result recorded as "beneficiary not reached," "declined to participate," or completed survey. Overall, 78.5% of respondents stated that they were responsible for canceling the trip, while 6.9% stated that the doctor canceled the trip, 3.8% stated the vehicle never arrived, and 10.8% gave another reason. Due to only two beneficiaries experiencing a vehicle not showing and rescheduling their trip, no analysis was conducted to evaluate assistance from LogistiCare.

CAHPS 2018 Survey

Results from the HEDIS-CAHPS 5.0H Survey for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following three survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare: Center for the Study of Services, DSS Research, and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2017 through December 31, 2017, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

The survey drew, as potential respondents, adult enrollees over the age 18 years, who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2018 using a mixed-mode protocol. All five

health plans utilized a mail and telephone protocol. Additionally, ABHNJ offered the option to complete the survey online. No adult survey respondents completed the survey online. The four-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 all members who had not responded to the first two survey mailings.

For the adult survey, a total random sample of 8,978 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,350 ABHNJ enrollees, 1,755 AGNJ enrollees, 1,755 HNJH enrollees, 1,620 UHCCP enrollees, and 2,498 WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 2,054 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 23.7%. Composite results of the adult NJ FamilyCare overall weighted positive responses for the five MCOs were: 90.6% for how well doctors communicate; 86.9% for customer service; 81.2% for getting needed care; 76.4% for getting care quickly; and 75.5% for shared decision making.

For the child survey, a total random sample of 10,940 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,650 ABHNJ enrollees, 2,145 AGNJ enrollees, 1,650 HNJH enrollees, 2,310 UHCCP enrollees, and 3,185 WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 2,799 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 26.2%. Composite results of the Child NJ FamilyCare overall weighted positive responses for the five MCOs were: 92.4% for how well doctors communicate; 87.5% for customer service; 84.7% for getting care quickly; 83.9% for getting needed care; and 75.2% for shared decision making.

For the CHIP survey, a total random sample of 2,145 parent/caretakers of CHIP child enrollees was drawn. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 583 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 27.5%. Composite results of the CHIP NJ FamilyCare overall statewide positive responses were: 95.1% for how well doctors communicate; 87.8% for getting care quickly; 86.1% for getting needed care; 82.0% for customer service; and 70.1% for shared decision making.

Care Management Audits

2018 Core Medicaid Care Management Audits

The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. The populations in the audits included the DDD, DCP&P and GP members.

The audits focused on identification, outreach, preventive services, continuity of care, and coordination of services for each population. The audit reports contained the findings of IPRO's MY 2017 audit with comparisons to MY 2016 audit results.

Assessment Methodology

IPRO identified the specific populations using enrollment and eligibility; removed the enrollees with TPL from the DDD, DCP&P and GP populations; and generated the random sample for each MCO. An off-site desk audit was carried out during March and April 2018 for the DDD, DCP&P and General populations. An electronic, standardized data collection tool was used. Following the audit, IPRO aggregated the MCOs' results by population and prepared audit reports. MCOs were not permitted to submit additional information after the onsite audit.

Summary of Audit Performance

Table 13 provides the results for the MCOs with comparisons to the previous year's findings. Shaded rates indicate scores that are at or above 90%. The 2017 rates across all MCOs, populations, and categories ranged from 70% to 100%. Scores for Continuity of Care and Coordination of Services were above 90% for all five MCOs for all (GP, DDD, and

DCP&P) populations in 2017. Scores for Identification for the DDD and DCP&P populations were all above 90% across all five MCOs in 2017.

Five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD, DCP&P, and GP) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 75 scores (**Table 13**). Out of the five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) across the General, DDD and DCP&P populations and across five plans that were comparable to 2016 (75 in total), twenty-four (24) scored higher, twenty-four (24) remained the same, and twenty-seven (27) scored lower in 2017.

WCHP scored at or above 90% in 14 out of 15 categories for all populations. ABHNJ and UHCCP scored at or above 90% in 12 out of 15 categories, and AGNJ and HNJH scored at or above 90% in 11 of 15 categories (**Table 13**). ABHNJ showed the greatest improvement in any category, with a 24 percentage point increase in Preventive Services for GP, followed by a 14 percentage point increase for HNJH in Outreach for the DCP&P population. WCHP had the highest number of categories (7 out of 15) with an increase, most notably a 12 percentage point increase in Identification and Preventive Service categories for GP and a 10 percentage point increase in Outreach and Preventive Service for the DCP&P population. A 17 percentage point decrease for UHCCP in Preventive Services for GP was the largest decline from 2016 to 2017.

Table 13: Care Management Audit Results

Response by Category	MCO									
	ABHNJ		AGNJ		HNJH		UHCCP		WCHP	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
General Population	n = 100	n = 101	n = 100	n = 100	n = 102	n = 100	n = 102	n = 100	n = 98	n = 100
Identification	74%	85%	92%	86%	89%	83%	92%	96%	80%	92%
Outreach	88%	83%	87%	88%	70%	72%	86%	85%	93%	97%
Preventive Service	67%	91%	79%	88%	100%	89%	87%	70%	65%	77%
Continuity of Care	99%	100%	99%	96%	97%	98%	99%	90%	99%	91%
Coordination of Services	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
DDD	n = 18	n = 27	n = 36	n = 30	n = 100	n = 100	n = 66	n = 53	n = 21	n = 20
Identification	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%
Outreach	97%	100%	100%	97%	89%	87%	98%	99%	100%	100%
Preventive Service	88%	87%	100%	87%	93%	94%	90%	87%	100%	92%
Continuity of Care	95%	99%	100%	97%	95%	90%	100%	99%	100%	100%
Coordination of Services	100%	100%	100%	99%	98%	100%	99%	97%	100%	98%
DCP&P	n = 27	n = 35	n = 100	n = 113	n = 100	n = 104	n = 100	n = 100	n = 20	n = 26
Identification	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outreach	100%	97%	100%	100%	86%	100%	99%	100%	87%	97%
Preventive Service	98%	98%	97%	97%	94%	98%	96%	94%	86%	96%
Continuity of Care	100%	100%	100%	99%	99%	100%	100%	99%	95%	99%
Coordination of Services	100%	100%	99%	99%	100%	100%	99%	99%	98%	100%

DDD: members under the Division of Developmental Disabilities (DDD); DCP&P: members under the Division of Child Protection and Permanency; N/A: not applicable. Blue shading indicates scores at or above 90%.

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

ABHNJ

ABHNJ audit results ranged from 83% to 100% across all populations for the five categories.

ABHNJ compliance rates improved for three categories for the General Population (Identification, Preventive Services and Continuity of Care). One category remained the same (Coordination of Services) and one category declined (Outreach). Two categories for the DDD population (Outreach and Continuity of Care) showed improvement, one category declined slightly (Preventive Services), and two categories remained the same (Identification and Coordination of Services). The DCP&P population demonstrated a slight decline for one category (Outreach) and four categories (Identification, Preventive Services, Continuity of Care and Coordination of Services) remained the same.

Successful outreach, although not considered for scoring purposes, was noted for 62% of the General Population, 85% of the DDD population and 86% of the DCP&P population. For the General Population, completion of a CNA was evident in 100% of cases and 100% of cases included a timely and complete care plan. For the DDD population, completion of a CNA was evident in 100% of cases and 96% of cases included a timely and complete care plan. The 2017 results continue to demonstrate improvement for completion of a timely and complete care plan (from 89% in 2016 to 96% in 2017). ABHNJ should continue to ensure that a care plan is developed for all DDD members regardless of whether a member declines care management services or is unreachable to complete a CNA. For the DCP&P population, completion of a CNA was evident in 100% of cases and 100% of cases included a timely and complete care plan.

The Preventive Services score was 91% for the General Population, 87% for the DDD population and 98% for the DCP&P population. The 2017 results for the General Population demonstrate significant improvement from last year (67%). ABHNJ should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 83% of members in the General Population, 92% in the DDD population and 100% in the DCP&P population. Although improvement is noted for the General Population and the DDD population, (from 50% for the General Population and 86% for the DDD population), ABHNJ should ensure that dental needs are addressed for all populations, particularly the General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

Although not considered in scoring, documentation of a BMI percentile/value for all populations should be encouraged. Early detection of overweight and obese members is important to allow for timely intervention and education.

AGNJ

AGNJ audit results ranged from 86% to 100% across all populations for the five audit categories.

AGNJ's compliance rates improved for two categories for the General Population (Outreach and Preventive Services), remained the same for one category (Coordination of Services), and declined for two categories (Identification and Continuity of Care). All categories for the DDD population declined. The most significant decline was in the category of Preventive Services. The DCP&P population demonstrated a slight decline for one category (Continuity of Care) and four categories remained the same (Identification, Outreach, Preventive Services and Coordination of Services).

Successful outreach, although not considered for scoring purposes, was noted for 78% of the General Population, 90% of the DDD population and 93% of the DCP&P population. For the General Population, completion of a CNA was evident in 90% of cases and 100% of cases included a timely and complete care plan. For the DDD population, completion of a CNA was evident in 96% of cases and 93% of cases included a timely and complete care plan. For the DCP&P population,

completion of a CNA was evident in 100% of cases and 98% of cases included a timely and complete care plan. AGNJ should continue to develop a care plan for all DDD and DCP&P members regardless of whether a member declines care management.

The Preventive Services score improved for the General Population, from (79% to 88%), declined for the DDD population from (100% to 87%) and remained the same for the DCP&P population (97%). AGNJ should continue to focus on age-appropriate immunizations for the adult population enrolled in care management and the provision of EPSDT exams for the child population. Confirmation of lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 100% of members in the General Population, 94% in the DDD population and 97% in the DCP&P population. AGNJ's should ensure that dental needs are addressed for all populations, particularly the General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

Although not considered in scoring, documentation of a BMI percentile/value for all populations should be encouraged. Early detection of overweight and obese members is important to allow for timely intervention and education.

HNJH

HNJH audit results ranged from 72% to 100% across all populations for the five audit categories.

HNJH compliance rates improved for two categories for the General Population (Outreach and Continuity of Care), remained the same for one category (Coordination of Services) and declined for two categories (Identification and Preventive Services). Two categories for the DDD population demonstrated improvement (Preventive Services and Coordination of Services), one category remained the same (Identification) and two categories declined (Outreach and Continuity of Care). Compliance rates improved for three categories for the DCP&P population (Outreach, Preventive Services and Continuity of Care) and two categories remained the same (Identification and Coordination of Services).

For the past three audits, the Outreach category was identified as a priority area for improvement efforts. For the General Population, the Outreach category improved from last year (70% to 72%). The Outreach category showed a decline for 2017 for the DDD population (89% to 87%). For the DCP&P population, the Outreach category improved from (86% to 100%) in 2017.

Similar to prior years, the low rate for timely outreach for the General Population was largely attributed to untimely outreach to members with newly diagnosed chronic conditions and/or multiple hospitalizations. HNJH should ensure that ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members demonstrating potential care management needs.

Successful outreach, although not considered for scoring purposes, was noted for 81% of the General Population, 93% of the DDD population and 97% of the DCP&P population. For the General Population, completion of a CNA was evident in 100% of cases and 91% of cases included a timely and complete care plan. For the DDD population, a completion of a CNA was evident in 98% of cases and 68% of cases included a timely and complete care plan. The rate for a timely and complete care plan decreased significantly from the 2016 rate of 86%. For the DCP&P population, completion of a CNA was evident in 99% of cases and 99% of cases included a timely and complete care plan. HNJH should develop a care plan for all DDD members regardless of whether a member declines care management services or is unreachable to complete a CNA, as well as all General Population members identified with care management needs. An individualized care plan should be developed using all available information including but not limited to, CNA results, input from DDD and DCP&P care managers, caregivers, member's PCP, member claims, etc. and should be updated over time as more information about the member's needs becomes available. HNJH should continue to develop a care plan for all DDD and

DCP&P members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services score for the General Population declined from 100% in 2016 to 89% in 2017. The Preventive Services score was 94% for the DDD population (an increase from 93%) and 98% for the DCP&P population (an increase from 94%). HNJH should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of EPSDT exams for the child population. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 93% of adult and child members in the General Population, 100% in the DDD population and 92% in the DCP&P population. The rate for the DCP&P population improved from last year (75%). HNJH should ensure that dental needs are addressed for all populations, particularly DCP&P members, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

Although not considered in scoring, documentation of a BMI percentile/value for all populations should be encouraged. Early detection of overweight and obese members is important to allow for timely intervention and education.

UHCCP

UHCCP audit results ranged from 70% to 100% across all populations for the five audit categories.

UHCCP's compliance rates improved for one category for the General Population (Identification), remained the same for one category (Coordination of Services) and declined for three categories (Outreach, Preventive Services and Continuity of Care). One category for the DDD population (Outreach) showed improvement, one category remained the same (Identification) and three categories declined (Preventive Services, Continuity of Care and Coordination of Services). The DCP&P population showed slight declines for two categories (Preventive Services and Continuity of Care), two categories remained the same (Identification and Coordination of Services) and one category (Outreach) improved.

Successful outreach, although not considered for scoring purposes, was noted 85% of the General Population, 72% of the DDD population and 100% of the DCP&P population. Completion of a CNA was evident in 100% of cases and 98% of cases included a timely and complete care plan for the General Population. For the DDD population, completion of a CNA was evident in 100% of cases and 96% of cases included a timely and complete care plan. For the DCP&P population, completion of a CNA was evident in 99% of cases and 98% of cases included a timely and complete care plan. UHCCP should continue to develop a care plan for all DDD and DCP&P members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services score for the General Population declined from 87% in 2016 to 70% in 2017. The Preventive Services score was 87% for the DDD population and 94% for the DCP&P population. The child immunization rate further declined for the DDD population from 71% to 67%. This rate improved for the DCP&P population, from 89% to 98%. UHCCP should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

The lead screening rate declined for the General Population, from 82% in 2016 to 50% in 2017, and the DCP&P population from 94% in 2016 to 75% in 2017. UHCCP should continue efforts to ensure age-appropriate lead screening. Confirmation of lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented for all populations, as well as attempts to obtain lead status or to provide reminder that a lead screening is due.

Dental needs were addressed for 42% of adult and child members in the General Population, 94% in the DDD population and 100% in the DCP&P population. For the General Population, this rate continued to decline, from 95% in 2015, to 79% in 2016 to 42% in 2017. UHCCP should ensure that dental needs are addressed for all populations, particularly the General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

Although not considered in scoring, documentation of a BMI percentile/value for all populations should be encouraged. Early detection of overweight and obese members is important to allow for timely intervention and education.

WCHP

WCHP audit results ranged from 77% to 100% across all populations for the five audit categories.

WCHP's compliance rates improved for three categories for the General Population (Identification, Outreach and Preventive Services), and declined for two categories (Continuity of Care and Coordination of Services). Three categories for the DDD population (Identification, Outreach and Continuity of Care) remained the same and two categories declined (Preventive Services and Coordination of Services). The DCP&P population demonstrated improvement for four categories (Outreach, Preventive Services, Continuity of Care and Coordination of Services) and one category (Identification) remained the same.

Successful outreach, although not considered for scoring purposes, was noted for 58% of the General Population, 60% of the DDD population and 92% of the DCP&P population. For the General Population, completion of a CNA was evident in 100% of cases and 88% of cases included a timely and complete care plan. For the DDD population, completion of a CNA was evident in 100% of cases and 100% of cases included a timely and complete care plan. For the DCP&P population, completion of a CNA was evident in 100% of cases and 96% of cases included a timely and complete care plan. A care plan should be developed for all DDD and DCP&P members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services score was 77% for the General Population, 92% for the DDD population and 96% for the DCP&P population. Although the 2017 results for the General Population demonstrate improvement (from 65% last year), this category remains below the 80% threshold.

WCHP should focus on age-appropriate immunizations for the child and adult populations enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 83% of members in the General Population, 83% in the DDD population and 100% in the DCP&P population. Although improvement is noted for the General Population (from 65%), WCHP should continue to ensure that dental needs are addressed for all members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

Although not considered in scoring, documentation of a BMI percentile/value for all populations should be encouraged. Early detection of overweight and obese members is important to allow for timely intervention and education.

2018 MLTSS HCBS Care Management Audits

The purpose of the annual MLTSS HCBS CM audit was to continue to evaluate the effectiveness of the contractually required MLTSS CM programs of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the

community or CARS within the review period from 7/1/2017 through 6/30/2018. The results from the previous review period (7/1/2016–6/30/2017) were compared to the 2018 audit, which includes the new results from 7/1/2017–6/30/2018.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated July 2017. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/17 and 1/1/18 (Group C) and existing MMC members enrolled in MLTSS between 7/1/17 and 1/1/18 (Group D), the 2018 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/17) and continuously enrolled with the MCO in MLTSS through 6/30/18. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files.

In order to achieve a denominator of 100 members for MLTSS PM #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS), an additional ancillary group of 25 HCBS MLTSS members were randomly selected and abstracted from subgroups C and D.

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

Performance Measure Results

Table 14 presents a summary based on file review of the MCOs' performance for the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS), #9 (Member's plan of care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS HCBS plans of care that contain a back-up plan, if required), and #16 (Member training on identifying/reporting critical incidents). Results were compared from the prior review period (7/1/2016 to 6/30/2017) to the current review period (7/1/2017 to 6/30/2018) for Groups C, D and E. Rates were calculated as the number of "Yes" determinations (numerator) divided by the sum of the "Yes" plus "No" determinations (denominator) based on documentation provided for offsite review. Cases scored as "N/A" (not applicable) were not included in the numerator or denominator at the measure level.

Across all plans, the total NJ weighted average for the 7/1/2017–6/30/2018 audit results for Groups C, D and E ranged from 7.6% for PM#11 Plans of care developed using "person-centered principles" to 96.2% PM #16 Member training on identifying/reporting critical incidents.

Table 14: MLTSS HCBS Care Management Audit Performance Measure Results for 7/1/2017 to 6/30/2018

Performance Measure[1,2]	Group	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[3]		
		7/16 to 6/17	7/17 to 6/18	PPD	7/16 to 6/17	7/17 to 6/18	PPD	7/16 to 6/17	7/17 to 6/18	PPD	7/16 to 6/17	7/17 to 6/18	PPD	7/16 to 6/17	7/17 to 6/18	PPD	7/16 to 6/17	7/17 to 6/18	PPD
#8. Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS[4]	C	30.5	36.4	5.9	88.4	18.8	-69.7	87.2	76.0	-11.2	87.2	50.0	-37.2	90.0	50.0	-40.0	72.9	42.3	-30.6
	D	24.4	27.8	3.4	80.7	23.6	-57.1	83.6	84.6	1.0	86.4	62.3	-24.1	84.4	66.3	-18.1	74.5	57.0	-17.5
	E																		
	TOTAL	28.0	33.3	5.3	84.0	22.1	-61.9	85.0	82.5	-2.5	87.0	58.3	-28.7	85.0	65.4	-19.6	73.8	52.4	-21.4
#9. Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary[5]	C	100.0	100.0	0.0	75.0	CNC	N/A	100.0	100.0	0.0	CNC	0.0	N/A	CNC	CNC	N/A	85.7	60.0	-25.7
	D	N/A	0.0	0.0	66.7	66.7	0.0	77.8	87.5	9.7	CNC	100.0	N/A	75.0	50.0	-25.0	63.2	72.7	9.5
	E	50.0	60.9	10.9	84.6	100.0	15.4	94.1	85.0	-9.1	83.3	81.8	-1.5	75.0	62.5	-12.5	83.3	76.3	-7.0
	TOTAL	44.4	60.0	15.6	80.0	85.7	5.7	88.9	86.7	-2.2	83.3	76.9	-6.4	75.0	61.1	-13.9	78.4	75.0	-3.4
#9a. Member's plan of care is amended based on change of member condition[6]	C	0.0	0.0	0.0	100.0	0.0	-100.0	100.0	40.0	-60.0	75.0	CNC	N/A	50.0	CNC	N/A	73.3	25.0	-48.3
	D	0.0	100.0	100.0	50.0	41.7	8.3	62.5	100.0	37.5	0.0	CNC	N/A	0.0	50.0	50.0	30.0	65.4	35.4
	E	25.0	100.0	75.0	0.0	66.7	100.0	100.0	100.0	0.0	0.0	0.0	0.0	0.0	100.0	100.0	16.7	84.6	67.9
	TOTAL	14.3	66.7	52.4	30.0	41.2	11.2	80.0	84.2	4.2	42.9	0.0	-42.9	7.1	71.4	64.3	37.7	63.8	26.1
#10. Plans of care are aligned with members needs based on the results of the NJ Choice Assessment[7]	C	52.2	100.0	47.8	97.4	60.9	-36.5	93.5	100.0	6.5	85.7	87.5	1.8	85.7	83.3	-2.4	81.1	89.5	8.4
	D	65.7	88.0	22.3	90.9	36.8	-54.1	92.0	100.0	8.0	94.7	96.3	1.6	92.0	97.4	5.4	87.9	84.2	-3.7
	E	52.6	100.0	47.4	88.9	100.0	-11.1	88.9	100.0	11.1	100.0	81.8	-18.2	72.2	100.0	27.8	80.2	96.2	16.0
	TOTAL	57.0	97.0	40.0	93.0	55.0	-38.0	91.9	100.0	8.1	90.0	91.0	1.0	88.0	97.0	9.0	84.0	88.0	4.0
#11. Plans of care developed using "person-centered principles"[8]	C	45.7	7.7	-38.0	57.9	30.4	-27.5	83.9	5.3	-78.6	73.0	0.0	-73.0	85.7	0.0	-85.7	65.4	9.7	-55.7
	D	54.3	4.0	-50.3	61.4	7.0	-54.4	76.0	3.3	-72.7	84.2	0.0	-84.2	66.7	1.3	-65.4	67.3	2.9	-64.4
	E	47.4	0.0	-47.4	100.0	90.0	-10.0	61.1	0.0	-61.1	50.0	0.0	-50.0	72.2	0.0	-72.2	65.9	17.0	-48.9
	TOTAL	49.0	5.0	-44.0	67.0	29.0	-38.0	75.8	3.0	-72.8	71.0	0.0	-71.0	69.0	1.0	-68.0	66.3	7.6	-58.7

Performance Measure[1,2]	Group	ABHNJ 7/16 to 6/17	ABHNJ 7/17 to 6/18	ABHNJ PPD	AGNJ 7/16 to 6/17	AGNJ 7/17 to 6/18	AGNJ PPD	HNJH 7/16 to 6/17	HNJH 7/17 to 6/18	HNJH PPD	UHCCP 7/16 to 6/17	UHCCP 7/17 to 6/18	UHCCP PPD	WCHP 7/16 to 6/17	WCHP 7/17 to 6/18	WCHP PPD	NJ Weighted Average[3] 7/16 to 6/17	NJ Weighted Average[3] 7/17 to 6/18	NJ Weighted Average[3] PPD
#12. MLTSS Home and Community-Based Services (HCBS) plans of care that contain a back-up plan[9]	C	54.8	87.9	33.1	38.1	9.1	-29.0	100.0	100.0	0.0	75.8	100.0	24.2	40.0	100.0	60.0	67.2	81.1	13.9
	D	42.9	72.0	29.1	52.4	8.9	-43.5	93.5	96.4	2.9	92.9	96.3	3.4	75.7	92.1	16.4	70.6	74.5	3.9
	E	68.8	85.0	16.2	26.7	21.4	-5.3	100.0	100.0	0.0	76.9	92.9	16.0	72.2	94.4	22.2	66.7	81.2	14.5
	TOTAL	52.4	82.1	29.7	43.6	11.1	-32.5	96.3	97.7	1.4	80.0	96.3	16.3	73.2	92.8	19.6	68.9	77.0	8.1
#16. Member training on identifying/reporting critical incidents	C	58.7	98.1	39.4	86.8	91.3	4.5	93.5	94.7	1.2	79.4	100.0	20.6	14.3	100.0	85.7	75.7	96.8	21.1
	D	57.1	88.0	30.9	84.1	96.5	12.4	92.0	100.0	8.0	89.5	98.1	8.6	6.7	96.1	89.4	56.1	96.7	40.6
	E	84.2	95.8	11.6	100.0	95.0	-5.0	88.9	100.0	11.1	94.4	81.8	-12.6	11.1	100.0	88.9	75.8	94.3	18.5
	TOTAL	63.0	95.0	32.0	88.0	95.0	7.0	91.9	99.0	7.1	84.0	95.0	11.0	8.0	97.0	89.0	66.9	96.2	29.3

[1] Groups A & B were only included in prior audits as subpopulations that converted to MLTSS on 7/1/2014.

[2] Rates for 7/16 to 6/17 and 7/17 to 6/18 for each managed care organization (MCO) are presented as percentages. The year-to-year difference is presented in the percentage point difference (PPD) column as percentage points.

[3] The weighted average is the sum of all numerator compliant charts divided by the sum of all charts in the denominator.

[4] Compliance with PM #8 was based on establishing an initial plan of care (POC) within 30 days in July 2015–June 2016; subsequently, this was changed to allow for 45 days for July 2016–June 2017 and July 2017–June 2018.

[5] For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period.

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

[7] Members are excluded from this measure if they do not have a completed NJCA or a completed POC.

[8] In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC.

[9] Members in CARS are excluded; in July 2015–June 2016, additional members are excluded if not receiving any of the following HCBS services that allow the member to remain in their home: home base supportive care, including participant directive services; in-home respite, skilled nursing; and/or private duty nursing.

C: Group C, members new to managed care and newly eligible to MLTSS; D: Group D, current members newly enrolled to MLTSS; E: Group E, members enrolled in the MCO and MLTSS prior to the review period; CNC: could not calculate; N/A: not applicable; PPD: percentage point difference between the prior year and the current year.

The findings reported are from the 2018 HCBS reports. PMs #8–#12 all relate to the POC. Where opportunities for improvement existed in the HCBS reports, they were discussed herein. PM #16 was not an opportunity of improvement for any of the MCOs, as it was above 85% for all MCOs (**Table 14**). Based on the reported MLTSS PMs, IPRO made the following key observations for each MCO for the current review period:

ABHNJ

Total results of ABHNJ's 7/1/2017–6/30/2018 MLTSS PMs ranged from 5.0% for PM #11 (Plans of care developed using "person-centered principles) to 97.00% for PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. Based on all subgroups combined, the MCO scored above 85% in two (2) of the seven (7) PMs.

PMs #8–#12, which are derived through the HCBS CM audit, focused on aspects of the initial and ongoing POCs. ABHNJ's opportunities for improvement for these measures include the following: for all three groups, the MCO should ensure there is documentation to reflect a member-centric approach, which demonstrates involvement of the member in the development and modification to the agreed-upon goals; this includes that the member and member representative, as applicable, are reflected in the documentation as present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the POC. For Group C, the MCO should ensure that documentation includes a member rights and responsibilities statement tailored for the MLTSS member, signed by the member 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. For Group D, the MCO should ensure that a risk assessment is completed and includes documentation of whether a positive risk was identified or not (as well as indication of a positive risk requiring a risk management agreement) for members residing in their community home; additionally, the MCO should ensure that documentation includes a member rights and responsibilities statement tailored for the MLTSS member, signed by the member 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.

AGNJ

Total results of AGNJ's 7/1/2017–6/30/2018 MLTSS PMs ranged from 11.1% PM#12 (MLTSS Home- and Community-Based Services [HCBS] plans of care that contain a back-up plan) to 95.0% PM#16 (Member training on identifying/reporting critical incidents) in the review period. Based on all subgroups combined, the MCO scored above 85% in two (2) of the seven (7) PMs.

PMs #8–#12, which are derived through the HCBS CM audit, focused on aspects of the initial and ongoing POCs. AGNJ's opportunities for improvement for these measures include the following: for Group C, the MCO should ensure that a signed risk management agreement with all of its components is documented when a positive risk indicator requires a risk management agreement. For Group D, the MCO should ensure a member-centric approach demonstrates involvement of the member in the development and modification to the agreed-upon goals when applicable; this includes that the member and 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 POC. For Group C and Group D, the MCO should ensure a completed and signed initial POC is provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program and that goals in the initial POC meet the four criteria. For all three groups, the MCO should ensure that there is documentation of a completed and signed back-up plan using the State-mandated form.

HNJH

Total results of HNJH's 7/1/2017–6/30/2018 MLTSS PMs ranged from 3.0% for #11 (Plans of care developed using "person-centered principles") to 100.0% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. Based on all the subgroups combined, the MCO scored 85% or above in four (4) of the seven (7) PMs.

PMs #8–#12, which are derived through the HCBS CM audit, focused on aspects of the initial and ongoing POCs. HNJH's opportunities for improvement for these measures include the following: for all three groups, the MCO should ensure a member-centric approach demonstrates involvement of the member in the development and modification to the agreed-upon goals when applicable; this includes that the member and 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 POC. For Group C, the MCO should ensure documentation of the member rights and responsibilities statement are tailored for each MLTSS member, signed by the member 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.

UHCCP

Total results of UHCCP's 7/1/2017–6/30/2018 MLTSS PMs ranged from 0.0% for PM #9a (Member's plan of care is amended based on change of member condition) and PM#11 (Plans of care developed using "person-centered principles) to 96.3% for PM #12 (MLTSS Home and Community-Based Services [HCBS] plans of care that contain a back-up plan) for the review period. Based on all the subgroups combined, the MCO scored above 85% in three (3) of the seven (7) PMs.

PMs #8–#12, which are derived through the HCBS CM audit, focused on aspects of the initial and ongoing POCs. UHCCP's opportunities for improvement for these measures include the following: for all three groups, the MCO should ensure a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals (which include that the member and/or member representative is present during the development of his/her goals, options are offered, that there is opportunity to express needs or preferences, and that needs or preferences were acknowledged and addressed in the POC). For Groups C and D, the MCO should ensure risk management agreements are signed and included with all components when there is positive indication of risk. For Group D, the MCO should ensure communication with the member's PCP in developing the care plan, and that goals meet 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). For Group E, the MCO should ensure contact with the members' HCBS providers at least annually to discuss the providers' reviews of the members' needs and status, and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury, or behavioral health services (for the necessary duration that members receive such services).

WCHP

Total results of WCHP's 7/1/22017–6/30/2018 MLTSS PMs ranged from 1.0% for PM #11(Plans of care developed using "person-centered principles) to 97.0% for PM#10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) and PM#16 (Member training on identifying/reporting critical incidents) in the review period. Based on all the subgroups combined, the MCO scored 85% or above in three (3) of the seven (7) PMs.

PMs #8–#12, which are derived through the HCBS CM audit, focused on aspects of the initial and ongoing POCs. WCHP's opportunities for improvement for these measures include the following: for all three groups, the MCO should ensure a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals (which include that the member and/or member representative is present during the development of his/her goals, options are offered, that there is opportunity to express needs or preferences, and that needs or preferences were acknowledged and addressed in the POC). Furthermore, for Group D, the MCO should ensure risk management agreements are signed and included with all components when there is positive indication of risk.

2018 MLTSS Nursing Facility Care Management Audits

The purpose of the MLTSS NF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. 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 of "Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Facility (SCNF)" are consistent with professionally recognized standards of care. The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, Article 9 from the State

of New Jersey DHS, and DMAHS MCO Contract to provide services dated July 2016 and January 2017. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in an NF or SCNF for at least six consecutive months within the review period from 7/1/2016 through 6/30/2017.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care and Contract references. IPRO prepared an audit tool structured to collect requirement-specific information related to three categories: 1) A Plan of Care for Institutional Settings; 2) NF/SCNF Members Transferred to HCBS; and 3) HCBS Members Transferred to the NF/SCNF. The "Plan of Care for Institutional Settings" category was identified as the audit focus. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data with capitation codes to identify MLTSS HCBS and NF/SCNF enrollment. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. IPRO selected 110 cases including an oversample of 10 cases to replace any excluded files as necessary, which included MLTSS members permanently residing in NF/SCNF between 7/1/2016 through 6/30/2017 (Group 1), MLTSS members residing in an NF/SCNF for at least six consecutive months between 7/1/2016 and 6/30/2017 and transitioned to HCBS for at least one month during the review period (Group 2), MLTSS members residing in HCBS for at least one month and transitioned to an NF/SCNF for at least six consecutive months during the review period (and still residing in the NF/SCNF) at the end of the review period (Group 3), and MLTSS members residing in HCBS for at least one month, transitioned to an NF/SCNF for at least six consecutive months, and transitioned back to HCBS for at least one month during the review period (Group 4). Members residing in an NF/SCNF less than six consecutive months at any time between 7/1/2016 and 6/30/2017 were excluded from the study. If the MCO did not have 100 files, the entire universe was selected for review.

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

Summary of Results

Table 15 displays MCO results based on care management file review for the period of 7/1/2016-6/30/2017. The reported rates include members from Group 1–3. Results were limited due to the low volume of members identified in Groups 2 and 3. AGNJ and HNJH were the only MCOs that had members identified in Groups 1, 2, and 3. Based on file review, none of the MCOs had members in Group 4 during the review period.

Rates were calculated as the number of "yes" determinations divided by the sum of the "yes" plus "no" determinations. Requirements scored as "not applicable" (N/A) were not included in scoring. Results will be used as baseline data for annual comparison.

Across all five MCOs in the "Plan of Care for Institutional Settings" category, three MCOs scored above 85% and two scored below 85% for demonstrating coordination of care (**Table 15**). Three of the five MCOs scored above 90% for having the member present and included in onsite visits by the care manager. All five MCOs have an opportunity for improvement to include copies of facility plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.

Two MCOs had members that fell in the "NF/SCNF Member Transferred to HCBS" category. Three review elements scored above 85% for one MCO. One of the two MCOs scored 33% for having a New Jersey Choice Assessment completed to reassess a member for NF/SCNF member transferred to HCBS. It was noted that one MCO scored 100% in three of the eight review elements, and one MCO scored 67% in three of the eight review elements; however, caution

should be taken while interpreting these results due to the low number of care management records reviewed for some of the elements. One MCO had an opportunity for improvement in IDT meeting attendance pertaining to member transfer to an HCBS setting. Two MCOs had an opportunity to amend the POCs prior to discharge from the facility.

Only two MCOs had members that fell in the "HCBS Members Transferred to an NF/SCNF" category. As a result, a comparison could not be made across MCOs. Both MCOs documented a discussion with the member prior to change of service/placement.

Table 15: MLTSS NF Care Management Audit Results for 7/1/2016–6/30/2017

Category	2017 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Plan of Care for Institutional Settings															
Copies of Facility Plans of Care on File	53	100	53%	60	100	60%	75	100	75%	29	100	29%	58	100	58%
Documented Review of a Facility Plan of Care	29	100	29%	45	100	45%	52	100	52%	33	100	33%	26	100	26%
MLTSS Plan of Care on File Includes Information from the Facility Plan of Care	48	53	91%	53	60	88%	58	75	77%	19	29	66%	20	58	34%
Completion of Initial Plan of Care	1	42	2%	17	47	36%	18	35	51%	11	39	28%	6	33	18%
Agreement/Disagreement with Plan of Care	56	100	56%	23	100	23%	80	100	80%	55	100	55%	27	100	27%
Written Member Goals Include All 5 Components	85	100	85%	0	100	0%	3	100	3%	29	100	29%	26	100	26%
Plan of Care Developed with Person-Centered Principles	86	100	86%	50	100	50%	78	100	78%	60	100	60%	32	100	32%
Member Included in the Development of Goals	88	100	88%	58	100	58%	84	100	84%	62	100	62%	32	100	32%
Identification of Member for Transfer to HCBS	94	100	94%	95	100	95%	91	100	91%	93	100	93%	94	100	94%
Plan of Care Addresses Formal and Informal Services	100	100	100%	90	100	90%	98	100	98%	91	100	91%	60	100	60%
Participation in Facility IDT Meetings	3	100	3%	4	100	4%	21	100	21%	2	100	2%	7	100	7%
Timely Onsite Review of Member Placement and Services	22	100	22%	40	100	40%	63	100	63%	37	100	37%	19	100	19%
Member Present and Included in Onsite Visits	98	98	100%	53	99	54%	93	98	95%	73	88	83%	80	85	94%
Coordination of Care	14	14	100%	21	32	66%	23	25	92%	7	7	100%	5	6	83%
Training on Identifying/Reporting Critical Incidents	49	100	49%	55	100	55%	76	100	76%	42	99	42%	0	100	0%
Updated Plan of Care for a Significant Change	1	7	14%	0	11	0%	9	23	39%	3	7	43%	0	8	0%
Completion of New Jersey Choice Assessment	95	100	95%	86	100	86%	93	100	93%	76	100	76%	88	100	88%
Completion of PASRR Level I and Level II, if applicable, Prior to Transfer to an NF/SCNF	7	7	100%	6	6	100%	14	18	78%	6	8	75%	5	6	83%
Communication of PASRR Level I	7	7	100%	5	6	83%	14	18	78%	4	8	50%	5	5	100%
Communication of PASRR Level II	1	1	100%	0	0	N/A	1	3	33%	0	2	0%	0	0	N/A
Coordination with DDD/DMAHS for Specialized Services Setting	0	0	N/A	0	0	N/A	0	2	0%	0	1	0%	0	0	N/A
Care Manager Explains Any Payment Liability	0	0	N/A	0	0	N/A	0	0	N/A	0	1	0%	0	0	N/A
NF/SCNF Member Transferred to HCBS															
NJCA Completed Prior to Discharge from a Facility	0	0	N/A	0	1	0%	1	3	33%	0	0	N/A	0	0	N/A
Cost Effectiveness Evaluation Completed Prior to Discharge from a Facility	0	0	N/A	0	1	0%	1	3	33%	0	0	N/A	0	0	N/A
Plan of Care Prior to Discharge from a Facility	0	0	N/A	0	1	0%	1	3	33%	0	0	N/A	0	0	N/A
Person-Centered Transition Plan of Care on File	0	0	N/A	0	1	0%	2	3	67%	0	0	N/A	0	0	N/A
Participation in an IDT Related to Transition	0	0	N/A	1	1	100%	2	3	67%	0	0	N/A	0	0	N/A

Category	2017 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Authorization and Procurement of Transitional Services	0	0	N/A	1	1	100%	2	3	67%	0	0	N/A	0	0	N/A
Services Initiated upon Facility Discharge According to Plan of Care	0	0	N/A	1	1	100%	1	3	33%	0	0	N/A	0	0	N/A
Face-to-Face Visit Within 10 Business Days Following a Facility Discharge to the Community	0	0	N/A	0	1	0%	1	3	33%	0	0	N/A	0	0	N/A
HCBS Members Transferred to an NF/SCNF															
Member Provided Opportunity to Select HCBS and Enter a Risk Management Agreement	0	0	N/A	0	0	N/A	0	1	0%	0	0	N/A	0	0	N/A
Documentation of Discussion with the Member Prior to Change of Service/Placement	0	0	N/A	2	2	100%	3	3	100	0	0	N/A	0	0	N/A

N: numerator; D: denominator; N/A; not applicable.

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

The BBA, Section 42 CFR section 438.364(a)(6), states that the EQRO (IPRO) "must provide an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed MCO-specific recommendations from the IPRO previous QTR, which entailed EQR activities from April 2016 to December 2017. The following is the MCO responses addressing each recommendation. Recommendations are presented in italics with bullets and MCO responses are included verbatim under each recommendation.

ABHNJ

ABHNJ addressed IPRO's April 2016-December 2017 QTR recommendations as follows:

- *The plan should develop a program designed for the identification, prevention and reduction of healthcare disparities. This program should include evidence of a quantitative assessment of disparities. The plan should evaluate its existing disparities and develop an action plan that specifically addresses the disparities observed.*

Population assessment was completed as part of the plan's NCQA accreditation process. In addition, Aetna Medicaid developed a Health Care Equity (HCE) Dashboard accessible by all plans, which provides numerous data points regarding ethnicity, language, utilization and other data that can increase the robustness of ongoing population assessment and identify geographical, ethnic and language indicators of disparity. The population assessment, other NCQA analysis documents and the HCE Dashboard will underlie development and monitoring of the Plan's Health Care Disparity project.

The Plan has chosen to identify areas with a high prevalence of diabetes in counties with sizeable populations of individuals that identify predominantly as Hispanic and Spanish speaking.

ABHNJ is currently able to accurately determine specific health care disparities through the HCE population health dashboard. The HCE dashboard allows the plan to apply filters in order to identify sub populations, variations in utilization of services and HEDIS outcomes.

A Health Care Disparities work group has been created and began to meet as of 5/14/17 with a plan for quarterly recurring meetings in order to finalize plans formulate implementations and develop monitoring strategy.

ABHNJ selected Essex County as the area for intervention to positively impact the Hispanic population through a comprehensive diabetic management outreach campaign. The Plan will look to improve Hemoglobin A1c testing adherence, nephrology screening, and retinopathy vision screening while simultaneously addressing healthy living habits. A mailer has been developed with a focus on members who have Hispanic backgrounds. These mailers highlight areas of high risk and provide instruction on healthy living and preventive care. Steps have been taken to partner with Shop Rite (a large supermarket chain local to NJ) with events such as a Diabetes Healthy Grocery Store Tour, a Balance Your Plate Demo and in-store blood pressure, glucose and cholesterol screening. Events will be sponsored by Aetna but will be open to the general public. The plan has developed a Health Disparities work group that has met 5/14, 6/13, 6/22 and 7/6, all in 2018. On-going meetings will continue to review outcomes based on outreach and attendance at sponsored events as well as to discuss efforts that will further impact the selected community.

- *The plan should continue to recruit for their dental network to address deficiencies in Atlantic, Morris and Sussex Counties.*

Attention to the dental network has been a significant priority with the dental vendor. Formal operations meetings occur every quarter with dental vendor DentaQuest to address network deficiencies and outline recruitment efforts. The last scheduled DentaQuest meeting was 4/17/18 and addressed county deficiencies. Multiple new providers have been added to the dental network. During the last scheduled meeting it was determined that there were 54 dentists moving

through the credentialing process and, once this is completed, the network would meet the adequacy requirements. Meeting frequency has been increased to 8 times per year. ABHNJ's Dental committee and DentaQuest had the third quarter Operations meeting in June 2018. It was determined at that time that the network met adequacy requirements in all 21 counties.

- *The plan should continue to expand the MLTSS network to include at least two providers in at least one county for community residential services, medical day services, social adult day care, structural day program, supported day services, and TBI behavioral management.*

With regard to Medical Day providers, structured Day Programs, Supported Day Services and TBI Behavioral Management, a system issue was discovered that led to inaccurate network reporting; the error was corrected and efforts are being taken to reconcile providers such that network reporting will be accurate. A comprehensive list of providers specific to community residential services, Medical Day services, Structured Day programs, supported day services and TBI Behavioral management will be re-created in an effort to measure recruitment efforts and adequacy.

Provider Data Services (PDS) is a national shared service that maintains the network data. PDS has been working with ABHNJ to address provider data and claims issues. This collaborative effort has been in effect for 8 months and meets every Monday to discuss progress.

- *The plan should analyze its utilization of services for the elderly, disabled and MLTSS subpopulations to identify any relationship to adverse or unexpected outcomes of care.*

ABHNJ developed a work group to review and evaluate utilization of services by the elderly and disabled populations, utilizing reports already developed, but with refinements to assure desired stratification. Components of the work group's processes and outcomes include the following:

1. Data will be sorted by population to ensure focused efforts; this includes separation as ABD, MLTSS and other categories of membership

2. Data will be broken down further by provider panel to identify baseline rates that will be used when determining targets

3. A formalized process for the distribution of plan data will created and adhered to on a quarterly basis beginning the end of the 2nd quarter

4. Focused provider outreach will be completed to raise awareness related to practice guidelines, utilization and outcomes specific to trends and other data findings

5. Provider newsletters will include information specific to the distribution and utilization of the plan data to drive quality outcomes for the Elderly and Disabled population

6. Data will be reviewed at least quarterly and distributed to the network

7. Data will be reviewed to determine the impact of sharing Elderly and Disabled data with providers

The Work Group commenced and has met 3/15, 5/15, and 6/12, all in 2018. Additional *ad hoc* meetings to discuss and revise previously developed data reports and best methods for presentation of the reports were held on 6/1, 6/6 and 6/24, all in 2018. A particular goal was to develop a provider profile suitable for communication back to providers. Provider information, population data and rates per 1000 will be included in next quarter's reporting. The Work Group will continue to meet quarterly and assure that all meetings include agenda, minutes and next steps. ABHNJ has decided to address the top 5 providers (by number of members cared for) with members having inpatient and Emergency Department utilization related to each relevant condition. Interventions will include the following: communicating their members' emergency department and inpatient utilization patterns, directing providers to practice guidelines, offering care management and discussing the implementation of tools such as the red, yellow green light for chronic disease management. Data trends will be reviewed quarterly to determine the impact of communicating data regarding their members' utilization, providing

focused education and offering relevant tools for care with the top 5 providers. Information pertaining to utilization patterns by disease will be included in the next provider newsletter along with instructions on how to access established clinical guidelines for care.

- *The plan should ensure that the results of the medical record audit are stratified to include the elderly, and/or disabled membership, and presented to the Quality Management Oversight Committee.*

As an outgrowth of a Work Group designed to review processes for ethical issues, it was determined that the Annual Medical Record Review process needed re-design. As a result, this became a component of the Ethical Issues meetings, which occurred 5/18/18, 6/1/18, 6/22/18, 6/29/18 and will meet again on 9/7/18. Changes to the process include the following:

1. Annual Medical Record Review (AMRR) sample will be pulled from all membership categories as defined by state capitation codes (CAP codes) to ensure inclusion of elderly, disabled and MLTSS members. Audit tools are already in place.

2. AMRR results will be stratified by member category (CAP codes) and inter-category comparisons made to identify any patterns or trends

3. Recommendations based on trends in record review results will be posted in the Provider newsletter to raise awareness

4. The AMRR tool was refined to assure inclusion of all questions necessary to address the particular provider type

5. The selection of provider types for medical record review was refined to assure inclusion of providers serving the elderly and disabled population and to remove certain provider types who were inadvertently included in prior audits

6. The quarterly AMMR results will be reviewed in the workgroup and reported up to QMOC.

- *The plan should continue to strengthen analytic support and address deficiencies in implementation and monitoring of its QIP for the MLTSS population.*

ABHNJ recognized the need to create a position to work with leadership on the development, implementation and oversight of Performance Improvement Projects (PIP). ABHNJ believes that this position will enhance the plan's ability to make significant and sustainable change.

1. Data is being pulled quarterly and will be reviewed in a formalized QIP/PIP meeting. The first meeting was held in May, 2018 and will recur at least quarterly thereafter. Additional measures for the project will be discussed and developed as part of the QIP/PIP workgroup.

2. Trends will be analyzed and focused interventions agreed upon. Quality Management and MLTSS will monitor progress based on the interventions being implemented.

3. Opportunities for QIP improvement and future interventions for the QIP to Reduce Falls will include rate of vision screening and patient centered interventions for members who are at greater risks for falls based on the Falls Risk Assessment findings

4. ABHNJ implemented a more robust Plan of Care (POC) which will offer the clinical team insight into factors resulting in a need for POC update. This was implemented in June of 2018.

ABHNJ anticipates that the newly created position of clinical lead for QIP/PIP implementation will be filled in quarter 3 of 2018. ABHNJ implemented a record review component to the Falls QIP/PIP in the 2nd quarter of 2018 and findings will be reported out in the August 2018 submission. The record review will look to assure that interventions are specific to the identified fall risk and that each assessment is accompanied by a QIP note. ABHNJ has included a care management intervention to increase the percentage of members who received a vision screening. In addition all members in Home and Community Based Care will receive a night light.

- *The plan should ensure timely resolution of member and provider complaints, grievances and appeals and appropriate notification to the member and/or provider. (Note that complaints will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments.)*

ABHNJ developed a set of interventions aimed to address timely resolution of provider complaints/grievances and appeals. These interventions are centered on a more robust auditing process completed by the department manager. The audit process includes daily random sampling of files to assure resolution timeliness. In addition the Chief Operating Officer and Compliance Lead will audit a monthly random sampling of files. ABHNJ recognized the need to add a 3rd Grievance and Appeal team member in November of 2017 and is planning on adding a 4th Team member in the 4th Quarter of 2018. ABHNJ believes that the auditing process and addition of new staff will assure compliance with contractual timeframes for provider complaints, grievances and appeals.

- *The plan should monitor dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.*

ABHNJ collaborated with DentaQuest (dental vendor) on the development of a report which tracks prior authorizations in place at time of entry to the plan. The report was developed in Nov. 2017 and has been reviewed quarterly since inception. The prior authorization report is used to monitor any and all prior authorization requests from other MCO's that the plan is made aware of. In addition to the aforementioned report ABHNJ has collaborated with DentaQuest on the development of a new report that captures prior authorizations that have been “consumed” (used) vs prior authorizations that have been submitted. The initial consumed versus submitted prior authorization will capture prior-authorizations from January 1, 2018 through June 29, 2018. This report will be run quarterly and reviewed at the Dental Advisory Committee meeting.

- *The plan should demonstrate timely member notification when a network provider terminates from the plan to ensure continuity of care.*

ABHNJ recognized the need to re-evaluate its member notification process when network providers are terminated. The plan developed a work group whose charge was to develop a standardized process for member notification when providers are terminated in order to assure continuity of care.

1. The work group developed a provider termination and member notification desktop (procedure) in April 2018 and the Member Services department training was held in May 2018

2. ABHNJ submitted a revised PCP termination "After Date Occurred" member letter to the state for approval on 4/13/2018

3. A nationally sponsored project workgroup entitled ABX ("Achieving Business excellence") for Credentialing commenced meetings as of April 1, 2018 in an effort to optimize the Medicaid credentialing process and assure compliance. This meeting will also look to develop a streamlined process for Member Service notification of all provider terminations which will flow to member notification

4. The manager of Member/Provider Services created a running provider termination log that will capture the date of all terminated providers to ensure member notification within the appropriate timeframes.

5. The manager of Member/ Provider Services also created a call code that will be used to track the date member notification was mailed to ensure adherence to time frames.

6. The Quality Manager and the manager of Member/Provider Services will review all terminated providers and timeliness of notifications of May 2018. Results of timeliness reporting will be presented to the Service Improvement Committee (SIC) and Quality Management Oversight Committee (QMOC) for adequate plan oversight.

The ABHNJ Credentialing work group met on 5/21, 6/5 and 6/15. During these meetings a Provider Termination Desktop (procedure) was created. The desktop clearly delineated responsible parties and addressed reporting capabilities. ABHNJ received approval from the state on the revised PCP termination letter to members on May 30th 2018. The plan utilizes a weekly informatics report in order to initiate the provider/member termination process listed above. The plan is able to view the dates each letter was generated and mailed via a call code. The manager will complete random audits of the terminated providers to assure that assigned members were notified timely. The results of these audits will be reported up to QMOC. The revised process and desk top allows for insight into the plan's ability to meet contractual time lines.

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

ABHNJ implemented multiple Interventions which will be included in this year's HEDIS work plan. These interventions are focused on addressing areas where clinical performance was subpar in comparison to the NCQA benchmarks, especially areas where clinical performance fell below the NCQA 50th percentile. Interventions include:

- The Plan developed and implemented member outreach campaigns
- ABHNJ also implemented a member incentive program which includes the following HEDIS measures: BCS, AWC, CCS, Lead and PPC
- Members will receive a 15 dollar incentive for each Gap in Care (GIC), i.e. missing HEDIS measure, that is filled, for a total amount of 45 dollars maximum
- The plan implemented on-site provider collaboration to review GIC reports and review proper coding techniques that assure providers receive credit for the care being provided as documented
- On-site collaborations also include a dedicated HEDIS coordinator who provides outreach to all members with a GIC who are assigned to the provider's panel
- ABHNJ provides support for providers with 60 or more members with a subsequent GIC
- ABHNJ has continued to develop its Provider incentive program, which include providers identified in the top 50-75 provider groups who are part of the Primary Care Alliance Initiative (a focused program for largest and other closely collaborating providers to provide enhanced attention and an account manager)
- ABHNJ has implemented a vendor outreach program using an electronic call service for the following measures; Well-Child Care, Dental Visits, Post-Partum Care and Adult Preventative Visits

ABHNJ believes that the robust nature of the interventions described above will have a positive impact on the 2018 measurement year rates. The plan has already begun to experience a year over year improvement.

- *The plan should improve the EI QIP study question (aim statement) and study variables (performance indicators), by clarifying the long-term and short-term successes for increasing the rate of early intervention services, as well as the specifications of indicators to ensure outcomes measure improvement. The plan should clarify parameters of the study population and sampling methods by ensuring the measurement and look back periods are appropriate for assessing characteristics of the study population. The plan should improve data collection procedures and plans for analyses by improving descriptions of data sources, as well as the specifications of indicators, to ensure systematic methodology to maintain validity and reliability of collected data. The plan should clarify the timeline for data collection, analysis and reporting.*

ABHNJ recognized the need to dedicate resources to the success of the Early Intervention (EI) QIP. Dedicated staff would be responsible to work collaboratively with the leadership on the development of a technically sound QIP. The additional staffing worked to assure that the interventions in question were rewritten, short and long term goals were adjusted and that performance indicators are now in alignment with the intent of the EI QIP. The revised QIP was submitted and accepted by IPRO. The first update was completed by the plan, submitted, accepted and returned by

IPRO with minimal feedback. ABHNJ will continue to make the necessary changes to assure accurate results and quality outcomes.

- *The plan should focus on age-appropriate immunizations for the child population enrolled in CM. The plan should ensure that dental needs are addressed for General Population members enrolled in care management, including documentation of the last visit date.*

ABHNJ has created a preventative screening template which is used by the ICM department for all members enrolled in Case Management. The preventative screening template focuses on age-appropriate immunizations, dental needs for the General Population and is inclusive of the last dental visit date. In an effort to drive dental utilization the plan has contracted with a vendor to complete dental outreach calls for all members and has included dental utilization as a measure in our Value Based Savings arrangements. Please see Recommendation #10 for additional details on outreach efforts to improve HEDIS measures.

- *The plan should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an individual health screen (IHS) for newly enrolled General Population members. The plan should also continue to ensure that timely and adequate attempts are made to reach members for completion of the comprehensive needs assessment (CNA) when potential CM needs are identified through completion of the IHS or other sources.*

ABHNJ has taken steps to assure Individual Health Screenings (IHS) are completed within 45 days of enrollment. The state approved vendor (Eliza) now completes all outreach calls within 45 days of enrollment. Eliza is contracted to make 2 calls and mail a letter if the member is not reached. Since implementing this process outreach attempts have increased to an average of 917 per month over the last 6 months. If the IHS score is above 5 it is referred to a care manager (CM) for continued outreach. This process yielded an average of 80 members per month in 2018. ABHNJ and its dedicated team of Case Managers understand the importance of completing the Comprehensive Needs Assessment (CNA) as it relates to assuring quality patient care. The team performs an aggressive outreach campaign to locate and connect with the member. Steps taken throughout this CNA outreach campaign include claims review, pharmacy utilization and a review of the daily inpatient report to attempt to locate members in need of a CNA.

- *The plan should review its MLTSS CM system to ensure the MCO will be able to meet the contractual requirements for HCBS MLTSS CM.*

ABHNJ reviewed the case management system and made the necessary updates to assure that all contractual requirements for HCBS MLTSS members are being met. This was achieved through a collaborative effort with our internal partners as well as state regulators on the development of a new format for the comprehensive plan of care. The state approved the Plan of Care documentation in May and it was implemented in June of 2018.

- *The plan should ensure the HCBS MLTSS members' plan of care is based on "person-centered" principals completed, signed and given to the member and/or authorized representative in a timely manner. Back-up plans should be reviewed and signed on a quarterly basis as appropriate. As part of ongoing care management, the plans of care should be completed on an annual basis in a timely manner, and updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the member and/or authorized representative. File documentation should address training a member and/or representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation.*

ABHNJ worked to develop a person centered plan of care and process that meets all of IPRO's and the State's expectations. These enhancements include:

- Staff meetings have included training on the development of a person centered plan of care.
- Training topics include the value of New Jersey Choice assessment findings, triggered clinical assessment protocols and member involvement in addressing identified areas of need.

- ABHNJ is committed to ensuring that members are educated on all available options and are encouraged to be active participants in their care plan development.
- The MLTSS management team developed an updated care plan template which was submitted to DMAHS QM for review and approval.
- State-suggested modifications included a 12 month history of care plan review dates; member-specific goals to improve or maintain health, and member centered interventions that are measurable and time specific.
- The suggested modifications also included responsible parties as it relates to actions/interventions.
- The updated care plan template after modification was submitted to state for approval on Nov. 2017, approved in May 2018 and Implemented in June 2018.

ABHNJ has taken additional steps to assure that each item is fully understood and applied to the care planning process. This was achieved through a series of education and training completed during the following staff meetings: 7/26/2017 and 9/29/2017. ABHNJ's MLTSS department will continue to provide at a minimum quarterly training on person centered care plans. ABHNJ included specific staff training on the importance of PCP collaboration in the development of a person center plan of care. This training was completed on the following date: 11/10/2017. ABHNJ provided training on the importance of PCP involvement in the development of MLTSS member care plans.

- *The plan should ensure copies of facility plans of care are on file and reviewed, participation in facility interdisciplinary meetings (IDT), and timely onsite review of member placement and services in the MLTSS NF CM Audit.*

ABHNJ MLTSS department took steps to ensure that copies of facility plans of care are on file and reviewed. MLTSS Case Management protocol includes a dedicated team of Case Management Assistants who contact all members residing in a nursing facility. These calls are meant to obtain a copy of the nursing facilities' Plan of Care which is then linked to the members file. Once linked to the file the assigned case manager is responsible for its review to assure a collaborative approach to meeting the member's needs. In addition ABHNJ developed a monthly report which tracks the participation of MLTSS staff in Nursing Facility Inter Disciplinary Team (IDT) meetings. This report provides insight into the plan's success in engaging nursing facilities in an effort to participate in IDT meetings. In order to ensure accurate placement and services ABHNJ implemented a process in which the Outreach Team enters the member's placement, which is then confirmed by Case Management during face to face visits. The Placement Events are monitored monthly during the MLTSS Living Arrangement File "Week". During this week all Case Managers are required to submit a Living Arrangement file specific to their assigned case load which is validated by the team's supervisor. The MLTSS quarterly audit includes a question that pertains to the accuracy of placement and acts as an additional quality check.

AGNJ

AGNJ addressed IPRO's April 2016-December 2017 QTR recommendations as follows:

- *The plan should continue its efforts with regards to provider recruitment and improving access to care for adult PCPs, pediatric PCPs, specialists, hospitals and dentists in the deficient counties.*

1. Adult PCPs and Pediatricians/Hunterdon

In October 2017 Amerigroup resubmitted its' request to extend the waiver from the requirement in N.J.A.C. 11:24:6.3(a)1 to have a licensed acute care hospital in Hunterdon County as this had expired in July 2013.

Hunterdon Medical Center has not been willing to contract despite numerous attempts made by Amerigroup to do so. As a result of the Hospital's position, the physicians affiliated with the hospital- affiliated IPA in the county also will not contract with Amerigroup.

2. Adult PCPs/Ocean

Amerigroup has been focused on curing this deficiency in the geographic areas of Bayville 08721, Barnegat 08005, and Jackson 08527. The ability to recruit has been challenged by the non-participation of Hackensack-Meridian Health System's Ocean Medical Center.

While Amerigroup continue to make best efforts to cure these deficiencies, the single case agreement (SCA) process will be utilized should any members require such services and will coordinate any required transportation.

3. Adult PCPs and Pediatricians/Warren

Amerigroup has been focused on curing deficiencies within the County in the geographic areas of Phillipsburg 08865, Washington 07882, Belvidere 08723, and Blairstown 07825. The ability to recruit has been challenged by St. Luke's Warren Hospital's non-participation and its' acquisition of many of the PCP practices in these areas.

4. Specialists/Warren

The 1Q2018 geo access report demonstrates that Amerigroup meets all specialty requirements in Warren County, with the exception of Endocrinology. Amerigroup has been challenged with identifying a provider for recruitment that meets the geo access requirement and will agree to participate in our network.

While Amerigroup continues to make best efforts to cure these deficiencies, the single case agreement (SCA) process will be utilized should any members require such services and will coordinate any required transportation. In addition, Amerigroup is exploring the possibility of utilizing telehealth providers.

Amerigroup continues to stay focused on improving appointment availability for our Members.

To ensure compliance with state regulations, Amerigroup conducts annual Appointment Availability and After Hours audits. As a result of the findings for the 2017 survey conducted in June/July 2017, the following actions were executed:

1. Provider Relations implemented improvements in the clarity of information provided in the Access and Availability Standards, with particular focus on appointment availability requirements for urgent specialty care, urgent behavioral health/substance abuse care, and after-hours access. This was published in August 2017 and made available on the Amerigroup provider portal.

2. Continuing education and distribution of the Access and Availability Standards and monitoring of compliance is performed by Network Management Representatives during all provider on site meetings.

3. In addition to continuing to require all non-compliant providers to complete a formal corrective action plan (CAP),

a. All Adult PCPs and Pediatricians non-compliant in the 2017 after-hours survey received an in-person or telephonic educational service visit to ensure that corrective actions were implemented to improve access.

b. All practices non-compliant due to after-hours access to PCP or covering provider also received an in-person or telephonic educational service visit.

4. CAP collection began in 1st quarter 2018 and was completed May 17, 2018. Providers that did not complete the CAP will be evaluated for potential further action, up to and including termination.

5. Provider Relations has implemented a process to re-survey a sample non-compliant providers prior to the 2018 survey to confirm implementation of their corrective action plans. Random sample re-survey to verify implementation of CAPs was completed May 25, 2018.

6. Articles were published in the September 2017 and April 2018 provider newsletters that focused on specialty urgent care appointment availability and PCP after-hours access.

7. The April 2018 newsletter contains an article about access to care and a link to the provider website that contains the complete access and availability standards.

Hospitals: Amerigroup will; continue to seek to negotiate with hospitals in counties where deficiencies were noted and/or seek waivers with the State of NJ if applicable.

Dental: Effective July 1, 2018 Amerigroup has implemented a new dental vendor, Liberty Dental. Amerigroup has identified that Liberty has a much more robust provider network than the previous vendor, Healthplex. Successful recruitment was accomplished by continuing to pursue non-participating and non-interested offices. Liberty had personalized discussions with the providers to address fees, claims, potential patient issues, and concerns about participating in a government plan. This system appears to have worked well. Liberty will continue to use this approach with the counties that are not deficient in order to continually improve the network. Liberty recruits dentists by attending trade shows in New Jersey, utilizing online provider listings (www.yellowpages.com/www.superpages.com, NJ Dental Association at www.njda.org), competitor provider directories and Liberty internal databases. Grassroots efforts have even included door to door recruiting. Dental provider offices have been mailed recruitment packets with a competitive fee schedule and follow up calls are being made.

- *The plan should ensure timely resolution of member and provider complaints, grievances and appeals and appropriate notification to the member and/or provider. (Note that complaints will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments.)*

Amerigroup Appeal Staff have been re-educated on proper management of expedited member and provider medical necessity appeal files. Staff have also been re-educated on ensuring the file is correctly identified to reflect the appropriate appeal type - standard or expedited. Staff re-educated on policy expectations for notification of members for expedited appeal outcomes. The Quality Management department conducts a random sample of appeal files to monitor the appeals process. In addition, QM conducts ongoing review of monthly reports to identify any issues and address accordingly.

Amerigroup's health plan Member Complaints staff have been re-educated on contractual timeframes for the resolution of Member Grievances to ensure timely resolution within 30 calendar days from the date of receipt. Weekly meetings are held with manager and staff to review open cases and identify any issues that could potentially cause delay in resolution of the issue. Member Complaints staff have a desk top process in place which is a timeline for various steps throughout the grievance resolution process to ensure timely closure of the issue. Monthly reports are generated and timeliness is continuously reviewed.

Provider Grievances are tracked on a centralized tracking database by Regulatory. Provider Relations leads the plan Grievance Team in coordinating weekly meetings with Regulatory and the representatives from MLTSS, Ancillary, Compliance and the Corporate Account Manager to ensure resolution in accordance with the required timeframes mandated by the State regulatory agencies. In addition, the team continues with reoccurring weekly meetings with the Provider Relations Director to review grievances for appropriateness and any necessary approvals. Weekly reports are generated and tracked to resolution.

Quarterly reporting of all provider grievance appeal requests and dispositions for the reporting period is submitted for the reporting period on Table 3C. In addition, the health plan responds with updates to the Provider Inquiry report received from DMAHS following their review of Table 3C.

- *The plan should monitor dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.*

Liberty and Amerigroup are committed to ensure continuity of care for ALL members during the dental vendor transition as well as ongoing continuity of care situations. To further clarify the transition of care actions by Liberty:

1. Liberty will work with any provider who is resistant to negotiate fees or will not contract with Liberty to get the patient taken care of. Single case agreements that outline the services, timeframes and fees to be paid can be put in place for a

specific member and provider that addresses that particular patient's situation. Liberty's experience across the country has been that providers will enter into single case agreements for specific patients who are in treatment with them as it is also in the provider's best interest to ensure their patient is taken care of as well as to avoid any complaints of patient abandonment.

2. Any existing prior authorizations from Healthplex will be honored until their expiration dates (assuming the member is still covered).

3. All members can continue to see their dentists for 120 days following transition if provider is OON to complete any work in progress.

4. Member services will work with these members over the 120 days to determine the best fit for a new dental home.

- *The plan should demonstrate timely member notification when a network provider terminates from the plan to ensure continuity of care.*

If a PCP ceases participation in Amerigroup's provider network, written notice will be sent to all affected members. Health Plan Operations submits a request to Provider Data Management which contains the provider information and the new PCP(s) assignments, which will be another participating provider in the same group or a PCP that meets PCP access standards. Enrollment moves members to the new PCP(s). Letters are generated to notify impacted members about the termination of their current PCP, information about the new PCP, continuity of care information, and the member's option to select a new PCP of their choosing by calling the Member Services Department. New ID cards are issued.

Members are notified at least thirty (30) business days prior to termination, but a good faith effort will be made to provide written notice within fifteen (15) days after receipt or issuance of a termination notice.

Amerigroup furnished copies of contractually required provider termination reports compliant with Managed Care Contract Section 4.9.3.B during the audit. DMAHS requires that these weekly reports be submitted through the State's secure DataMotion messaging system. For this reason, email documentation of the report submissions was not available to Amerigroup to provide to IPRO. Confirmation of the report submission and compliance history could be obtained from DMAHS however. In future audits Amerigroup will try to obtain screenshots during the State submission process of the provider termination report in order to have for IPRO review during the audit.

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

Amerigroup conducts ongoing monitoring of its rates and maintains a work plan to address areas where performance is below the 50th percentile. In 2017, Amerigroup achieved improved rates in 24 of its 28 accreditation specific measures when compared to 2016. Of the HEDIS measures only reported to the state, Amerigroup improved its rates in 75 of the measures.

- *The plan should identify and develop staff regarding QIP development, and closely monitor progress on the Reduction of Preterm Births by 5 (a re-working of the original Reduction of Preterm Births – Increasing Progesterone Utilization Rates QIP) to ensure interventions are implemented in a timely manner.*

The Preterm Birth QIP is assigned to dedicated clinical staff, who has become familiar with this QIP, and is tracking interventions and outcome measures through a QIP work plan. Amerigroup will continue to monitor progress on a quarterly basis, and with the transition to the enhanced IPRO PIP template anticipates that future interventions will be implemented more timely.

- *The plan should implement planned interventions in a timely manner to have an effective impact on the outcome of the Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population QIP.*

Amerigroup has adopted the enhanced IPRO PIP templates and has instituted bi-weekly meetings specifically with the LTSS team to ensure planned interventions are implemented in a timely.

- *The plan should improve the EI QIP project topic and relevance through use of recent, evidence-based literature that is better aligned with the scope of the study. The plan should improve the study variables (performance indicators) and data collection procedures to ensure the process and outcome measures (as well as their sources of data and data collection methodology) are clearly specified, and are able to reflect valid and reliable performance and quality improvement, as intended. The plan should clarify the timeline for data collection, analysis and reporting.*

Amerigroup has addressed all of IPRO's recommendations from the October submission. The PIP was updated with evidence-based literature and the performance indicators were improved to ensure more clarity throughout the PIP. Data sources, collection procedures and timelines have also been clarified throughout the PIP to ensure quality improvement as well as reliable performance.

- *The plan should implement a process to ensure that retrospective prior authorizations for Core Medicaid members are completed in a timely manner, including Core Medicaid members in need of MLTSS authorization of services (e.g., for NF).*

Amerigroup has dedicated staff to monitor members in Core Medicaid requesting MLTSS services such as NF. UM staff verifies members pending MLTSS enrollment in a NF monthly – if the member is not scheduled to enroll the following month, UM staff will extend the authorization. A compliance manager is dedicated reviewing all Core Medicaid members residing in a NF to ensure authorization is updated and accurate. Additionally, MLTSS enrollment staff is monitoring the same census to ensure members are screened, assessed and enrolled into MLTSS timely.

- *The plan should develop a process to ensure consistency between the dates of actual occurrences and electronic signature dates.*

Amerigroup continues to use multiple tracking systems simultaneously for care management, utilization management, storing documents and tracking compliance with different workflows. Amerigroup has implemented notes and processes to document activities occurring outside the clinical member record. When a member is referred for the MLTSS program, a note is entered to identify date of referral, referring associate, assigned RN, etc. Once the assessment is complete and transmitted to the State, an auto generated note is entered into the member's clinical record to document transmission. Once the State has received and authorized the assessment, a similar note is auto generated to document approval in the member's record. Amerigroup has also built the MLTSS screening tool, Nursing Facility transition tool, and falls screening tool directly into the clinical system. Amerigroup continues to ensure documentation pertinent to the member's clinical care is included in all primary systems. Additionally, Amerigroup anticipates a new system interface in 2019.

- *The plan should ensure the HCBS MLTSS members' plan of care is based on "person-centered" principals completed, signed and given to the member and/or authorized representative in a timely manner. Back –up plans should be reviewed and signed on a quarterly basis as appropriate. As part of ongoing care management, the plans of care should be completed on an annual basis in a timely manner. In addition, the care plan should be updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the member and/or authorized representative.*

In December 2017, Amerigroup developed a CM upcoming production report – this report pulls all members by CM due for a visit, annual NJCA, plan of care review, etc. The report is sent to each Amerigroup case manager monthly and an aggregate summary is distributed to the assigned manager and clinical director. Weekly, the report is refreshed to monitor progress with upcoming cases. The report also notifies CMs of overdue cases.

Amerigroup has developed reporting to monitor compliance with timely plan of care completion for new and existing MLTSS members. This report monitors the member's initial plan of care as well as quarterly updates and annual review.

The report is distributed to management monthly to review. Amerigroup is working to include the back-up plan to both reports for monitoring compliance.

In February 2018, Amerigroup field Care Management staff all received guidance on person-centered approach to care planning. Included in this guidance was necessary revisions of member-centric goals, member participation in review, prioritization of goals, cultural and linguistic needs, etc. 1:1 reeducation is completed between the CM and manager when documentation does not meet standards.

Amerigroup also developed a report and process to identify members with changes in authorized level of care to monitor CM process compliance. The report pulls all members that experience a change in living arrangement and/or level of care authorization. The report is distributed to management staff to ensure a visit has been completed, plan of care revised and all necessary documentation is in the system. Amerigroup is enhancing this report to pull assessment/face to face documentation automatically, increasing management capacity to complete review on other, non-reportable elements.

- *The plan should ensure copies of facility plans of care are on file and reviewed, participation in facility IDT, and timely onsite review of member placement and services in the MLTSS NF CM audit.*

Amerigroup MLTSS management team realigned the case management team to dedicate specific case managers to Nursing Facilities, Assisted Living Facilities and Home/Community members. Case managers were assigned by proximity and nursing facility to promote the MCO/CM relationship with the facility. This would also increase CM capacity to attend facility IDT meetings.

Additionally, the management team was shifted to ensure one manager oversees the CM Nursing Facility team. This realignment was completed in June 2018. The new manager provided a comprehensive overview of case management processes for members in an institutionalized setting. This review was completed on 7/2/2018 and all workflows/notes outlining these processes are available for the team for review at any time on a central, shared location. As part of the realignment process, Amerigroup dedicated two non-clinical staff to support facility case management.

Amerigroup updated the face-to-face visit template to include clear documentation that the facility plans of care are on file and reviewed by the case management during each visit. This note was implemented on 2/2018. The new manager is reinforcing documentation of collection and review during onsite monthly case management meetings.

Amerigroup developed a database that pulls face to face contact note narratives for reporting purposes. Next steps include modifying the database to measure compliance with this documentation. Currently, this element is being reviewed (random sample) monthly during the case management audit. Findings are/will continue to be reported on the quarterly CM audit report. Amerigroup will also ensure this element is included in manager audits.

Amerigroup is brainstorming a process for non-clinical support to screen all facility members for compliance – currently this requires a manual review. If an automated process is not identified by SFY Q1 2019, Amerigroup will assign all NF members for a manual review and subsequent ongoing review for new NF members.

HNJH

HNJH addressed IPRO's April 2016-December 2017 QTR recommendations as follows:

- *The plan should further develop its action plan to tackle identified barriers and make meaningful impact through robust interventions on the targeted population(s) and should implement ongoing quantitative monitoring of the implementation of those interventions to overcome healthcare disparities.*

As part of the strategic process to address healthcare disparities and effectuate change, Horizon NJ Health (HNJH) created a Healthcare Disparities Workgroup that includes active participation from various departments. These departments include representation from Quality, Care/Case/Disease Management, FIDE-DSNP, MLTSS, Marketing and Outreach, Network

Operations, and Medical Directors are also amongst some of the participants. As a recommendation from the Workgroup, HNJH developed an action plan to address the identified barriers complete with interventions that directly focused on targeted populations for a positive impact.

The action plan developed in 2016, and implemented in July 2017 and will continue for 2018. The following indicators are included: Performance and Measure definition with baseline data and an established goal, Barrier and Disparity analysis, Interventions, Effectiveness, and Monitor and Sustain. The progress toward the established goals is also documented and measured. Updates are reported monthly at the Healthcare Disparities Workgroup and quarterly at the Quality Improvement Committee.

A multi-disciplinary group reviewed the initial data and the analysis revealed certain at risk subpopulations. From the analysis, six topics were chosen to act upon: Breast Cancer Screening (BCS) - updated May 2017, Cervical Cancer Screening (CCS) - updated May 2017, Prostate Cancer – April 2018, Colorectal Cancer Screening – June 2018, Access to Specialty Services (DSNP) – August 2017, Depression in the Elderly (DSNP) – January 2018. Of those six, interventions have been implemented for four topics - Breast Cancer, Cervical Cancer, Prostate Cancer and Depression in the Elderly. Additionally, HNJH measures the effectiveness of actions taken to overcome healthcare disparities. HNJH evaluates outcomes and conducts impact analysis. Should the interventions be successful, HNJH can scale interventions to other populations. Interventions that did not have greater impact are assessed for barriers to change. The outcomes of the interventions are reported to the Healthcare Disparities Workgroup and to the Quality Improvement Committee.

- *The plan should ensure timely resolution of member and provider complaints, grievances and appeals and appropriate notification to the member and/or provider. (Note that complaints will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments.)*

To ensure timely resolution of member and provider complaints, grievances and appeals, HNJH implemented a new validation process for notifications. All grievances are entered into CareRadius and submitted to appropriate department for full review and resolution. The resolution is reviewed and approved by a Supervisor and an Analyst to ensure all necessary supporting documentation was provided before closure of the grievance.

This will allow the Supervisor to ensure the notification date is same as resolution.

As of 4Q 2017, HNJH developed and instituted systemic letters to address all member grievances received directly to HNJH and directly from DMAHS. When the grievance resolution is finalized, a letter is selected via our medical management system, CareRadius. The letter is generated and automatically sent to the letter generating system, where the letter is approved and released for mailing. Instituting this process ensures that notification will be disseminated at the time of the resolution.

Additionally, a Closed Grievance report inclusive of the auto generated letters is reviewed daily to validate that all letters have been generated for all member and provider grievances and to ensure the date of closure and resolution letter is the same day. These process improvements will ensure that HNJH maintains compliance.

- *The plan should monitor dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.*

HNJH monitors dental prior authorizations to guarantee implementation and completion of dental treatment for members. This includes members who are new to the MCO and have prior authorizations for treatment. To induce change, HNJH educated staff, updated workflows and policies and implemented a monitoring process.

To address this recommendation, HNJH focused additional efforts on education. In September 2017, the internal dental staff received education reiterating the contract requirement update regarding members that are transferred to HNJH and have active prior authorizations and may/may not be in the middle of treatment. The reeducation centered on ensuring the continuity of care as the member moved from one MCO to HNJH. HNJH's Customer Service staff received the written and

verbal education, which included pertinent information on continuity of care. HNJH will also provide education to dental providers on the prior authorization process and addressing member questions related to the continuation of their treatment via a provider mailing which is targeted to be sent by 9/01/2018.

HNJH updated the current workflow to comply with contract sections 4.6.5.D.4, 4.1.1.F, and 4.6.5.D.5. The prior authorization will be honored for as long as it is active or for six months, whichever is longer. Timeframes have been added that are relative to completion dates. Additionally, HNJH will also update the Prior Authorization policy to add verbiage that reflects the current mandate detailed in the contract sections by 9/01/2018.

HNJH conducts reviews of affected members to assess compliance with the continuity of care process. Each month, HNJH selects a sample of continuity of care cases (if any received) to review. This allows HNJH to monitor adherence to the new policy/process change. If deficiencies are identified, provider and member education will occur. This process was implemented in Q3/2017 and will continue throughout 2018.

- *The plan should demonstrate timely member notification when a network provider terminates from the plan to ensure continuity of care.*

To ensure continuity and care, HNJH notifies members when a network provider terminates from the Plan. In order to reevaluate the current process and identify areas for improvement, a cross functional review process was conducted in Q2/2018 to assess the terminations process.

Within 30 days of the receipt of the provider termination, HNJH notifies the member via letter of the termination with instructions on continuation of care. When a specialist terminates, the process includes an action to notify members serviced by the terminating specialist in the last 6 months prior to termination. To ensure that the process is occurring, system updates were made in 3rd quarter 2017 to reinstate the auto triggering of the member notification.

On a weekly basis, a Terminations report is reviewed by Health Services staff and Network Contracting stakeholders. This allows for identification and activation of transition plans. The Terminations report is sent to DMAHS weekly. Moreover, the PCP/Specialist terminations and member notifications are reviewed on a quarterly basis (effective 2nd quarter 2018) to ensure adherence to the established process and to identify process improvement opportunities.

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

To address the underperforming clinical measures that were was less than the NCQA benchmarks or fell below the 50th percentile, HNJH developed the HEDIS 2017 State Work Plan. The work plan also included the Lead Screening in Children (LSC) measure which required actions targeted to reach the 75th percentile. The work plan incorporates details related to barriers, overcoming barriers with opportunities for improvement and timeframes for implementation. HNJH submitted the work plan to DMAHS on August 15, 2017. HNJH monitors each measure on a monthly basis and reports progress toward goals at the HEDIS Workgroup meetings. Additionally, the HEDIS activities are reported quarterly at the Quality Improvement Committee.

The evaluation of the effectiveness of interventions allowed for the development of additional interventions to improve outcomes. The HEDIS 2018 State Work Plan will be submitted on August 15, 2018. It will contain all the interventions HNJH is currently implementing to improve our HEDIS measures.

- The plan should improve clinical performance for the Follow-up Hospitalization for Mental Illness measure.

To address the clinical performance for the Follow-up Hospitalization for Mental Illness measure, a CAP was developed and submitted to DMAHS on December 11, 2017 and will remain a focus in 2018. The CAP includes collaboration with Horizon Behavioral Health to improve provider and facility engagement, member engagement and data integrity.

To improve provider engagement, follow up is occurring with facilities that are not requesting prior authorizations for member hospitalizations for mental illness. Stakeholder meetings are held with each facility identified, to address deficiencies timely. As of 7/18/2018, 14 out of 18 identified facilities have engaged in meetings with Horizon; all facilities are being monitored for adherence to pre-authorization requirements. In addition to the prior authorizations, each facility is introduced to the care team to coordinate discharge and aftercare transitions. Education was conducted and workflows were updated with implementation of new workflows in 3rd quarter 2017. Outpatient providers were engaged to secure authorizations for follow up care at the time of discharge.

To address member engagement, HNJH implemented two initiatives. Upon admission, a mailer is sent to member's residence stressing the importance of follow up treatment and sharing pertinent contact information. Secondly, the Telephonic Outreach Workflow was enhanced to improve consistency and timeliness. The Aggressive Outreach protocol is utilized for members that are unable to reach.

The third opportunity to address is Data integrity. To improve the utilization of claims for outpatient treatment, HNJH implemented changes in provider specialty mapping.

In addition to the initiatives noted above, HNJH is monitoring the FUH measure closely with through weekly collaboration calls comprised of a multi-disciplinary team with the purpose of identifying and addressing barriers and/or deficiencies.

- *The plan should improve the EI QIP data collection procedures by further describing automated and manual processes, as well as clarifying data analysis plans.*

To improve data collection procedures for the EI PIP, HNJH will continue to strengthen analytic support and address deficiencies by maintaining and increasing efforts implemented in 2017 as needed. HNJH has a plan in place to address the recommendation for the EI PIP. HNJH will provide clarifications in the Baseline and Project Y1 Update Report that will be submitted in August 2018. HNJH will describe processes for manual and automated data collection including data retrieved from administrative claims, the medical management system, CareRadius, and the State Data Exchange. HNJH will correct the EI PIP table describing Intervention Timelines to reflect how the performance measures/interventions will be presented and clarifications on how often (i.e., quarterly, annually etc.) interventional data will be collected. HNJH will describe information on data analysis in further detail in the August Update Report.

Additional actions for 2018 include two components. HNJH is implementing a specific Analytics Team focus on the development and upkeep of data workflows, dashboards, and recurrent data request. This action ensures that data is consistently pulled and reported in an equivalent manner. This focus would include a review of recurrent monthly, quarterly and annual data requests that are automatically pulled using the same coding technique to ensure consistency. In 3rd quarter 2018, the Quality Improvement team will be cross training an additional resource within the team to increase the direct monitoring of the expected PIP outcomes as outlined in the proposal and to address deficiencies identified in implementation of the PIPs.

- *The plan should ensure that ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members of the General Population demonstrating potential care management needs. HNJH should also continue to ensure that timely and adequate attempts are made to reach newly enrolled DDD members for completion of the CNA within 45 days of enrollment. HNJH should continue to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.*

HNJH instituted new initiatives to ensure that Plan is utilizing methods to identify and outreach to members of the general population that may demonstrate the need for case management services. The following items were implemented to address the recommendation. HNJH transitioned from two medical management systems to one medical management system. On a monthly basis, a report is generated to demonstrate progression to meet outreach timelines. There is a weekly and monthly review of the percentage of completion of all outreach attempts (i.e. for first attempts, completed >95 within 30 days. For second attempts, 100 attempts made within 45 days). HNJH established a new report for members receiving 25 Personal Care Assistant (PCA) hours or less a week that are lacking case

management involvement. Case Management (CM) staff receives monthly notification that is prioritized by utilization and diagnosis.

HNJH reinstituted a diaper report inclusive of any member five years or older with an authorization for diapers. Like the PCA report, CM staff receives monthly notification that is prioritized by utilization and diagnosis. To broaden the scope, an "Appeals to Case Management" work flow was implemented for members engaged in the appeal process without CM involvement. Those members are referred to CM. HNJH offers a 24 hour nurse line, Axis Point. CM Supervisors review the mailbox daily for referrals to CM. Lastly, the diagnoses of CHF/Pneumonia is pulled from the daily Inpatient Census report. These specific diagnoses, prioritized by utilization, are sent in a separate notification to the CM staff on a daily basis.

To address the second part of the recommendation, HNJH will continue to ensure that timely and adequate attempts are made to reach newly enrolled DDD members for completion of the CNA within 45 days of enrollment. The following opportunities were implemented to address the recommendation. CM staff will touch every newly identified member within the first week of the month identified. HNJH will monitor the timeliness of the Complex Needs Assessment (C.N.A) completion and sign off for timely Care Plan development. HNJH will conduct a weekly review of the DDD production tracking ration to ensure timely outreach and completion of the C.N.A. CM management staff will conduct coaching for any staff identified as not meeting expectation.

In addition to the efforts indicated above, HNJH continues ongoing efforts to address the recommendation. CM management staff conducts ongoing monthly audits of CM staff. Several reports are reviewed and utilized for outreach efforts including the daily IP Census, the daily Predictive Model report for readmissions, daily monitoring of the member portal for disease management request, monthly Over-Utilizer report, the Monthly Chronic/Disease trigger report, the monthly Case Management trigger report, the quarterly Under-Utilization report, the quarterly Dual Eligible utilizations report and referrals from HNJH's Community Health Education programs.

HNJH submitted a CAP for outreach for general care management to DMAHS on 9/29/17. Approval of the CAP was received on 12/11/17 from DMAHS.

- *The plan should develop the capability to maintain multiple Cost Effectiveness Evaluation Forms in a member's HCBS MLTSS CM file.*

In May 2017, HNJH developed the capability to maintain multiple Cost Effective Evaluation Forms in the member's MLTSS CM file. In March 2017, HNJH submitted an enhancement to the medical management system, CareRadius to retain members' historic Cost Neutrality forms. That system update was made in May 2017, thereby establishing the ability for Care Managers to not only create and save a Cost Neutrality Tool when completing a member's Cost Effective Analysis, but also maintain the history of those updated CEAs in the member's electronic medical record. Whenever a change is required, the Care Manager must create a new Cost Neutrality and each one is stored and available in the Care Management file.

HNJH updated the Cost Effective Analysis (CEA) Operational Workflow on 4/10/2017 and again on 1/19/2018. The workflow provides detailed screen shots and instructions on how to properly complete the Cost Neutrality Tool in CareRadius. The CEA Policy and Procedure was updated on 2/3/17 and again on 2/5/2018 – which summarizes State Medicaid Contractual language regarding when a CEA is warranted and applicable standards within in the Care Managers' responsibility regarding MLTSS cost effectiveness considerations.

- *The plan should ensure the HCBS MLTSS members' plan of care is based on "person-centered" principals completed, signed and given to the member and/or authorized representative in a timely manner. As part of ongoing care, the care plan should be updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the member and/or authorized representative.*

HNJH bases the MLTSS members' plan of care on person centered principals. The plan is signed and disseminated to the member or personal representative in a timely manner. Should changes occur for the member, the plan is updated. Over the past year, HNJH's MLTSS Member Service Plans of Care (SPOC) have steadily advanced to meet State Medicaid Contract requirements. HNJH has implemented interventions to address the ongoing needs of the MLTSS membership.

In April 2017,'Person-Centered/SMART Goals' training was conducted for all MLTSS care management staff. The Power Point Presentation continues to be provided to staff on an ongoing basis and is also utilized in new hire onboarding training. In August 2017, HNJH implemented a SPOC Checklist while working with Information Technology to update the Medical Management System's SPOC to capture new Contract requirements. All care management staff was subsequently trained on the SPOC Checklist in September 2017. Additionally, HNJH added a new contact reason to assist the staff with documentation by indicating when the SPOC was Mailed or Hand delivered to the member.

In September 2017, HNJH put in a request to add another contact reason called "Unsigned Documents" to track and follow-up with Personal Representatives/POA or the member in order to obtain the necessary signatures. The enhancement became effective and the MLTSS CCC staff was trained in March 2018. The enhancement allowed monitoring of unsigned documents to resend them to the member or his/her representative for signature again. HNJH continues to utilize the MLTSS Dashboard to monitor SPOC activation and to ensure authorizations are accurately entered into the Medical Management system.

In December 2017, HNJH updated the SPOC Operational Workflow with the expectation that it would once again be updated, re-distributed, and training provided when the new SPOC was approved by the State for implementation in 2018. The Checklist and SPOC Workflow together were utilized as references to emphasize the importance of member goals being developed and/or updated appropriately, and were designed to be specific, measurable, and include the plan of action/intervention to be used to meet the goals, along with an identified timeframe for the attainment of the desired outcome. On July 1, 2018, the new State approved SPOC was implemented and adequately encompasses all required fields to improve the member's plan of care needs. All MLTSS Care Management Supervisors were trained in May 2018. MLTSS Care Managers were trained in June 2018.

HNJH's MLTSS Care Managers are readily supported in their ongoing care monitoring efforts to ensure the health and welfare of members and to update SPOCs as warranted based on significant changes in care. HNJH continues to have community-based provider use an "MLTSS Alert Form", and maintains a designated email address MLTSS _Alerts@ HorizonBlue.com for providers to notify the MLTSS Department of member events such as: falls, hospitalizations, or changes in condition. The MLTSS Alert Form was included in the Quarterly Provider Newsletter in October 2017.

- *The plan should ensure copies of facility plans of care are on file and reviewed participation in facility IDT meetings, and timely onsite review of member placement and services in the MLTSS NF CM audit.*

To meet the components of the MLTSS NF CM audit, HNJH has executed interventions to ensure facility plans of care are on file and reviewed participation in facility IDT meetings, and timely onsite review of member placement and services. In 2017 HNJH developed an MLTSS Nursing Facility (NF) Care Manager Workgroup, specifically designed to review, update and discuss issues and problem-solve to improve communication between NF providers and MLTSS Care Managers. The Workgroup met quarterly in 2017 and discussed various topics surrounding specific CM requirements such as participating in facility IDT, reviewing NF charts/plans of care, and facilitating transitions. Ongoing collaborative meetings with NFs are taking place to increase communication, compliance and coordination of care of our members.

Additionally, MLTSS Care Managers who manage a caseload with primary nursing facility-based members are scheduled to attend a mandatory staff meeting. The meeting will occur on August 7, 2018 and will address the specific care planning and monitoring standards required for their cases. At that meeting, training will be provided on documenting their process of review at the time of uploading the Nursing Facility Plan of Care to the CareRadius and will address the new guideline requirement of supplementing Nursing Facility Plans of Care on the HNJH Service Plan of Care for their members. The education will include recognizing indicators on the NF POC requiring supplementation and the type of documentation to include on the HNJH Service Plan of Care to meet requirements. In addition, electronic development

of the Service Plan of Care is in process which is anticipated to improve compliance rates in multiple facets involving this document.

HNJH currently assigns MLTSS Clinical Care Coordinators (CCC) to specific NF Care Managers and NF's. The CCCs involvement fosters improved coordination between the NF Staff and Care Managers with the goal of increasing the receipt of NF plans of care and HNJH IDT/Care conference participation. Additionally, HNJH created an 'Alert Form' that can be used specifically by facilities to communicate important issues such as, hospitalizations and IDT/Case Conference meetings to the MLTSS Care Manager. The utilization of the Alert Form has been minimal, as there has been resistance and lack of support from the NJ Hospital Association. A presentation to the NJ Hospital Association was completed on March 6th 2018 educating providers in attendance of the requirements of the MCO's under the MLTSS contract and the need for the Care Managers to participate in the NF IDT meetings.

Lastly, a system enhancement was requested in July 2018 to add the following Contact Note Types: "MLTSS Facility Care Plan Received" and "MLTSS Facility Care Plan Reviewed" to improve documentation and reporting/monitoring of these activities being completed by MLTSS Care Managers.

UHCCP

UHCCP addressed IPRO's April 2016-December 2017 QTR recommendations as follows:

- *The plan should address the network deficiencies for dental providers and hospitals.*

Since November 2017 to current June 2018 network deficiency reporting, UHCCP has demonstrated correction of the Primary Care Dental provider deficiency consistently month over month for all counties at over 90, which includes Cumberland County.

The 90 geoaccess requirement cannot be met for Sussex County since no other hospital exists to meet the 15 mile radius for all UHCCP NJ FamilyCare membership residing within that county.

UHCCP has been actively engaged with negotiating a contract with Inspira on a regular basis to improve the deficiency percentage in Cumberland County. The last outreach to Inspira was made again in March 2018 but the requested rate from the hospital remains significantly above the Medicaid fee schedule. It is the MCOs fiduciary responsibility to contract with providers at or near Medicaid rates. As such UHC submitted a proposal to Inspira in April 2018 that is still under review. We continue outreach to the facility in hopes of reaching an amicable arrangement.

- *The plan should monitor and provide evidence of the adequacy of the network for MLTSS providers.*

UHCCP emails quarterly updates to DMAHS detailing the adequacy of MLTSS providers and any actions taken to correct any deficiencies. UHCCP internally monitors the adequacy of the network on a monthly basis and identifies areas of opportunity for improvement.

- *The plan should address the ongoing deficiency with regard to obstetric care in the third trimester with its obstetrics and gynecology providers.*

After quarterly results were received back from the third party vendor with non-compliant providers reported, a UHC representative called each non-compliant provider to educate them on Access & Availability standards and to better understand the reasons why the providers were deficient in this area. The reasons were reviewed and further education was provided to clarify the requirement of Ob/Gyn providers seeing third trimester patients as well as PCP providers' requirement to have after-hours access by a UHC representative. The provider may be terminated from the network if they remain non-compliant after follow-up surveys, although this would be a last resort option. UHCCP's goal is to remediate the deficiency through provider education.

- *The plan should verify that it is able to identify populations and run accurate reports for the annual Core Medicaid/MLTSS audit as well as provide accurate file universes for onsite file review.*

United Healthcare Community Plan has developed a guidance matrix based on member eligibility mapping to identify the populations appropriately on reporting. UHCCP has also put in a process to conduct pre-audit small work group meetings to review the accuracy of the Universes and obtain approvals prior to the submissions.

- *The plan should ensure timely resolution of member and provider complaints, grievances and appeals and appropriate notification to the member and/or provider. (Note that complaints will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments.)*

We have implemented a number of processes to help ensure that member and provider complaints, grievances and appeals are processed and notifications are sent on time. Daily case inventory reports are reviewed to identify cases nearing their due date to ensure cases are completed on time. We have also developed an escalation process to ensure business partners complete any dependent work on time without delays that might impact timeliness of case completion. The team has a daily huddle to review compliance risks, escalate cases as needed and receive education about any compliance timeframe or process changes. A team review of any previous out of compliance cases is also done to discuss remediation and best practices along with individual processor coaching.

For any case that is found to be non-compliant, a root cause analysis is completed and remediation efforts are documented. Monthly reports are run to identify volumes, trends, and to ensure compliance with timeframes noted in our policies.

- *The plan should demonstrate timely member notification when a network provider terminates from the plan to ensure continuity of care.*

UHCCP currently submits weekly provider termination reports to DMAHS. With this reporting, UHCCP also ensures that member letters are mailed out with at least 30 calendar days' notice prior to the provider's termination, provided the provider notifies the plan with at least 60 calendar days written notice of determination to terminate from the network.

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

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2017)	Results
Childhood Immunizations - **Combo 2, 3, 4, 5, 7, 9, 10** - **Individual Antigens: DTaP, MMR, Hepatitis B, Varicella, Pneumococcal Conjugate, Hepatitis A, Rotavirus**	1 - EPSDT reminder letter to members 2 - Educational articles in member and provider newsletters 3 - Provider Profile mailing: list of non-compliant members 4 - CPC visits: Provider education related to timing and coding of immunizations 5 - Schedule well-visit clinics with network Providers to get members in for needed services. 6 - Continue Accountable Care Community Partnerships w/FQHCs- OHI 7 - Live outreach calls to members via QM Dept.	1 - Mailing completed: 11/2 2 - Article featured in the Summer member newsletter: Baby's Best Shot; Article published in Summer provider newsletter: Providing Complete Well Care for Children and Adolescents. 3 - Provider Profile mailings completed quarterly. 4 - CPC visits completed: 302 5 - No clinic days to report 6 - Ongoing review of results with ACO partners at least quarterly 7 - Calls completed: 9,223; Contacts: 1,483; Appointments scheduled: 267 8 - Ongoing 9 - Well visit postcard: 10,359; missed

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2017)	Results
	8 - Collect NJIIS data at least quarterly. 9 - Pfizer postcard mailing- well visit reminder and missed dose *10 - Implement PCPI provider incentive program 11 - Automated Calls via Silverlink	dose: 26,487 10 - Program Implemented 2Q 11 - Calls completed: 39,602
HPV	1 - Continue member well-visit movie incentive program clinic days at selected PCP offices 2 - Educational articles in Member newsletters 3 - Quarterly Provider Profile Mailing: list of non-compliant members 4 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes. 5 - Schedule well-visit clinics with network Providers to get members in for needed services. 6 - Automated Calls via Silverlink 7 - Live member calls via Silverlink	1 - Movie tickets rewarded to members that completed a well visit: 177 2 - Article featured in the Spring member newsletter: Check out check-ups Pre-teens and teens need annual doctor visits. 3 - Provider mailing completed quarterly. 4 - CPC visits completed: 302 5 – Adolescent Well Clinic held: 6/21 6 - Calls completed: 17,041 7 - Live calls discontinued 3Q
Comprehensive Diabetes BP Control (<140/90)	1 - Educational articles in member and Provider newsletters 2 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes 3 - Automated member calls - Silver Link *4 - Alegis home visits for BP, lab work, and education Alegis home visits will include BP, lab work, and education. 10 counties will be included: Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, Union.	1 - Article featured in Winter member newsletter: Under Control. Article featured in the Provider Fall/Winter newsletter: A reminder about CDC. 2 - CPC visits completed: 302 3 - Calls completed: 11,755 4 – Program deployed 8/1
Comprehensive Diabetes Nephropathy	1 - Educational articles in member and Provider newsletters 2 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes 3 - Automated member calls - Silver Link 4 - Live calls via QM department *5 - Alegis home visits will include BP, lab work, and education. 10 counties will be included: Bergen, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Passaic, Somerset, Union.	1 - Article featured in Winter member newsletter: Under Control. Article featured in the Provider Fall/Winter newsletter: A reminder about CDC. 2 - CPC visits completed: 302 3 - Calls completed: 11,755 4 - Calls completed: 13,147; contacts: 2,353; Appointments Scheduled: 254 5 – Program deployed 8/1

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2017)	Results
Follow-Up Care for Children Prescribed ADHD Medication-Initiation (ADD) - Initial Phase **Follow-Up Care for Children Prescribed ADHD Medication-Initiation (ADD) - Continuation and Maintenance Phase**	1 - Send email blast and articles posted on provider website. 2 - CPC visits to provider offices to review HEDIS quality scores, provide list of non-compliant members with gaps in care and provide measure definition and HEDIS codes. 3 - Educational articles in member and provider newsletters *4 - Implement PCPi provider incentive program	1 - Emails sent between 11/3-11/5/17 to 9 NJ BH practitioners. ADHD articles posted on provider website. 2 - CPC visits completed: 302 3 - Article featured in Fall member newsletter: The right dose; Article featured in Summer provider newsletter: Follow-Up for Children Prescribed ADHD Medication. 4 – Program implemented 2Q.
Frequency of Prenatal Visits (FPC)	1 - Educational article in member newsletter 2 - Automated Member Calls - Silverlink 3 - CPC program to continue provider visits to OB/Gyn practices to provide education of HEDIS measures. *4 - Implementation of PCP incentive program. PCPs can earn incentives for meeting health plan goals for HEDIS measures, including FPC. *5 - Implementation of revised Healthy First Steps Program. Program focuses on working with pilot practices (5) to identify pregnant members and follow members to ensure they are receiving services.	1 - Article featured in the Summer member newsletter, Health on Time. 2 - Calls completed: 33,501. 3 – OB visits scheduled: 16. 4 – Program implemented 2Q. 5 – Program implemented 2Q.
Annual Monitoring for Patients on Persistent Medications (MPM) - Digoxin	1 - Educational article in Provider newsletter	1 - Article featured in Fall/Winter Provider newsletter: Annual Monitoring for patients on persistent medications.
Medication Management for People with Asthma (MMA) - 75 **- Ages 5-11**	1 - Automated Member Calls - Silverlink 2 - Educational articles in member and provider newsletters 3 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes. *4 - Implement PCPI provider incentive program	1 - Calls completed: 1,431. 2 – Article featured in Fall Member newsletter: Take a deep breath, Understanding your asthma medication; Article featured in Fall/Winter Provider newsletter: Managing Medications for people with asthma. 3 - CPC visits completed: 302 4 – Program implemented 2Q

- *The plan should improve the EI QIP study question (aim statement) by ensuring their indicators for early intervention are appropriate for the scope of the study and the target population. The plan should clarify the timeframes, as well as the integration of process measures, for the improvement strategies (interventions).*

UHCCP Early Intervention QIP September 2017 Proposal Review Response	
Review Element 2 - Study Question (AIM Statement)	
The Y9434 code is not appropriate for the focus of this QIP. This code is for school-based rehabilitation, used for children in the school district, who are presumably aged three or older.	After reviewing the entire document, the only Y9434 code that was still in the document was on page 16. This was a typographical error and removed. It was not found in any other part of the document and was not used for the baseline or any analysis going forward.
As the plan had already mentioned, the threshold was previously 10 µg/dl for a high risk condition. The plan should indicate if there are special steps for those >10 µg/dl, as these should be an even higher priority.	The Lead Case Management Program utilizes a program care plan specifically for member's that are >10 µg/dl. All members regardless of lead level will receive an EI referral because the EI QIP has incorporated the required workflow of the Lead Case management program into the QIP.
Review Element 7 - Improvement Strategies (Interventions)	
Although the plan indicates that regular analyses to monitor the effectiveness of each intervention will be conducted, methodology for planning the development and integration of process measures could be further described. Based on frequent analysis, interventions may need to be modified, replaced or added as the QIP progresses to at least meet or exceed the QIP goals. Although the plan clearly presents initial process measures that are reported quarterly, it's not clear how often modifications will be made to the QIP and in what capacity. The plan should more concisely demonstrate how and when process measures are used for evolving interventions.	The following statement was updated in the QIP on page 21 to reflect the monthly meeting to address Process Measures and interventions: The Childhood Early Intervention QIP workgroup membership will consist of the Senior Quality Director, Medical Director, Clinical Quality Manager, Senior Clinical Quality RN, Quality Data Analyst, and the Lead Case Management team. The workgroup will meet on a monthly basis to review, track, and analyze all Performance Indicator and Process Measure reports provided by the Lead Case Management Clinical Program Consultant. In the event that the process measures are not having a measurable impact on the performance indicator, appropriate adjustments will be developed and implemented. Additionally, the process measures will be evaluated for measurable outcomes that contribute to an effective workflow on a monthly basis. This QIP will be updated and reported semi-annually through the existing Quality Improvement Committee reporting structure including all Performance Indicators and Process Measures that were modified and implemented during the previous reporting period. Additionally, The following statement was updated in the QIP on page 26 to reflect the monthly meeting to evaluate barriers: As interventions are implemented in 2018 and data is collected and analyzed, barriers currently not expected will be identified and addressed. Barriers will be evaluated and addressed at the Childhood Early Intervention QIP workgroup on a monthly basis and interventions will be modified as needed and new interventions will be implemented as appropriate.

- *The plan should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources.*

The NJ plan utilizes the care team to outreach to members by phone; face to face and auto dialer attempts. The WPC managers will reinforce the importance of the completing the CNA during team and staff meetings.

- *The plan should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations from a reliable source, such as the PCP, NJ immunization registry, DCP&P nurse should be consistently documented. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.*

The case managers will complete an assessment and review the member medical history to obtain immunization information using the UTD system. The mandated team and WPC case managers also use the HEDIS measures to obtain additional information for the children enrolled in the plan. The WPC managers will reinforce the importance of completing the documentation to the care plan and case management notes.

- *The plan should ensure the HCBS MLTSS Members' plan of care is based on "person-centered" principals completed, signed and given to the member and/or authorized representative in a timely manner. Back-up plans should be reviewed and signed on a quarterly basis as appropriate. As part of ongoing care management, the plans of care should be completed on an annual basis in a timely manner. In addition, the care plan should be updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the member and/or authorized representative. File documentation should address training a member and/or representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation.*

As of July 1, 2018, we implemented the MLTSS Plan of Care that was approved by the State. Signed copies of the MLTSS POC's are sent to the member/representative and PCP. In the event the member cannot sign for themselves and the representative isn't physically at the face-to-face visit, the representative is contacted in advance and/or during the visit and a copy of the POC is sent to them to sign and return with a self-addressed stamped return envelope. The CM makes multiple attempts to secure a signed copy of the POC and each attempt is documented. MLTSS Back up Plans are reviewed and signed at every face-to-face visit. That documentation is now more obvious due to a change in the system we use to capture it. We have also implemented a system based process and reporting that is based on the LOC approval date received from OCCO so that there is better Management oversight. In Q4 of 2017 we implemented the updated and State approved MLTSS Informational Letter that includes member education on how to report critical incidents, including abuse, neglect, and exploitation. This letter is signed for by the member and a signed copy is retained in the record. United is currently field testing the use of portable printers to be used in the field to facilitate the provision of signed documents at the face-to-face visit.

- *The plan should ensure copies of facility plans of care are on file and reviewed participation in facility IDT meetings, and timely onsite review of member placement and services in the MLTSS NF CM audit.*

Since implementation of MLTSS, the CM's have reviewed NF POC's and participated in facility IDT meetings when given the opportunity to do so by said facility. In Q3 2017, by directive, the Plan put into place securing copies of the NF POC at each NF visit to see a member saving them on file and that practice continues.

WCHP

WCHP addressed IPRO's April 2016-December 2017 QTR recommendations as follows:

- *The plan should evaluate the ongoing impact of their interventions for reducing healthcare disparities, following the first year of active interventions.*

Lead screening rates are monitored quarterly for race/ethnicity and county, and monthly for members residing in the city of Newark.

- Quarterly data will be presented at Population Health Committee and PAC committee.
- 2017 data following the 1st year of active interventions was evaluated with quantitative and qualitative analysis, and recommendations for 2018 which included: targeted quarterly telephonic outreach to parents/guardians to instruct on need for lead screening and assistance with making an appointment/transportation; education providers on $75 Bill above for Blood Lead Level (BLL) screening and MedTox; Member Incentive Program (Visa or MasterCard Gift Cards - $25 for EPSDT and/or $25 for lead screening) expanded from Newark to Hudson and Middlesex counties; participation in all MCO collaborative to increase BLL; HealthTag attached to prescriptions picked up at CVS pharmacies education member on the importance of lead screening and reminding members to call their PCPs.

- *The plan should address deficiencies in its pediatric PCP, dental provider, and hospital networks.*

Pediatric PCP:

1. Morris County: WellCare has contracted with a large pediatric PCP practice with providers in six locations across Morris, Sussex & Warren Counties. These providers are currently in credentialing. WellCare expects to see the impact of adding these providers in its Q3 or Q4 2018 GeoAccess submissions.

2. Mercer County: WellCare has met state GeoAccess standards in each quarter since at least Q4-2016.

3. Somerset County: WellCare has met state GeoAccess standards in each quarter since Q4-2016.

Dental Network:

1. Morris County: WellCare is actively recruiting dental providers in the deficient areas of Morris County and anticipates adding an additional practice in Lake Hopatcong in the very near future which should bring our GeoAccess score over the 90% State requirement.

2. Mercer County: WellCare has met state GeoAccess standards in each quarter since Q3-2016 and has added 15 dentists to its network since June 30, 2017.

3. Somerset County: WellCare has met state GeoAccess standards in each quarter since Q4-2016 and is actively recruiting dentists to add to its Somerset County network.

Hospital Network:

WellCare presently has a contract with Atlantic Health System-Newton Medical center that is the only Acute Care Hospital in Sussex County. We have contracts with the following hospitals that border Sussex County: St. Clares Health System, Hackettstown Medical Center, Chilton Medical Center and Morristown Medical Center. These facilities will provide adequate coverage to our members in Sussex County.

- *The plan should monitor their MLTSS HCBS network to ensure that they have contracted with at least two providers in each county, with the exception of services that are contracted on a statewide basis.*

WCNJ Network Integrity department uses Optum GeoNetworks software to measure GEO adequacy. WellCare has added two additional components, Quest Analytics Suite and GeoNetworks. This software enhanced reporting capability and is accessible via the Network Integrity share site. Quest is now operational and we are working on curing deficiencies. The monitoring of MLTSS provider adequacy as defined by our state and federal contracts, is performed by the Network Development Team. The additional software components allows for matching of the member file against provider locations, region and provider type. The expectations going forward, is that WellCare will continue to recruit for the specialties where there is a deficiency, and where needed, WellCare will use its existing contracted providers in adjacent counties and will use Single Case Agreements, as needed to provide service. In addition WellCare has added two additional Provider Services Representative positions to address recruitment of Behavioral Health specialties.

- *The plan should continue to audit their member and provider appeals and grievances processes to assure that turnaround times are met according to policy and procedure.*

Both the Appeals and Grievance Department have several mechanisms in place to ensure appeals and grievances are processed within the applicable state contracted timeframes. The Departments have a dashboard that runs daily to capture the department's daily inventory and lists all files that require acknowledgment and closure. The dashboard captures all expedited, pre-service retrospective appeals and grievances, the date of receipt, status of grievance, reason for appeal and grievance, line of business, compliance timeframe, and other pertinent information needed to manage the day-to-day operations of the departments. The Department's Sr. Director, Managers, and Supervisors use the dashboards to prioritize work and manage the inventory throughout the day to ensure cases are addressed and resolved according to established timeframes.

Team Supervisors and Team leads, will discuss processing timeframe goals and metrics on an on-going basis, assuring that all team members take accountability for processing files within the compliance timeframe. Reeducation will be giving as needed up to and including performance management as necessary for files that miss compliance. The appeals and grievance teams will also report trends and processing timeframes goals to the quarterly UMAC and/or QIC Committee meetings.

Turnaround time metrics are reported and monitored quarterly via the QI Work Plan and UMAC meetings.

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

MCO Response: WellCare's goal is to increase HEDIS ® rates to the NCQA 50th percentile or higher. Planned and ongoing interventions include: Inbound Care Gap Call Program (specially trained customer service representatives identify members making inbound customer service calls with care gaps specific measures targeted are: Adolescent Well Care Visits, Breast Cancer Screening, Cervical Cancer Screening, Chlamydia Screening in Women, Lead Screening in Children, Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life); HEDIS provider outreach and education; provider incentive program; EMR flat file transfer program to enhance data transfer capabilities; Pseudo claims initiative improvements designed to streamline data collection; HEDIS weekly meetings to discuss rate updates, progress on measures and program/initiative tracking for all lines of business; organized community outreach health workers to concentrate on providers in counties and zip codes with higher numbers of members; implemented and integrated cross-functional teams for quality initiatives; Quality Practice Advisors (QPAs) interfaced with 72 of the high volume providers who service the Medicaid population and provided verbal and written education to increase the quality of care to members and close care gaps; Provider newsletters and toolkits were also utilized to both inform and incentivize provider participation in quality health care improvement initiatives; partnered with community provider to conduct In- Home assessments to close care gaps; the Maternity Education and Reward Program (MERP) distributes educational materials and provides an incentive for members that complete the recommended number of prenatal visits and a postpartum visit.

- *The plan should continue to strengthen analytic support and address deficiencies in implementation of the Rate of Preterm Births in the NJ Medicaid Population QIP.*

WellCare plans to continue to strengthen analytic support and address deficiencies in implementation of the Rate of Preterm Births in the NJ Medicaid Population QIP through: Targeted face to face education by the Quality Provider Advisors (QPAs) to OB providers with updated OB Provider Toolkits which include information for referrals for smoking cessation, documentation template, information and prescription form for 17P/Makena; Quarterly analysis of Alere's Quarterly reports; continued review per IPRO PIP evaluation; Key QI and MLTSS staff to attend annual EQRO QIP/PIP Training; conduct quarterly analysis of data; Insures that key elements (interventions) can be operationalized before development and implementation; a QI Data Analyst and Sr. QI Project Manager with MA in Nursing Informatics and experience writing PIPs and CCIPs hired as of 1/2/2018 and will assist with interpretation and analysis of data.

- *The plan should continue to strengthen analytic support and address deficiencies in implementation of the Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall QIP.*

WellCare plans to implement activities to strengthen analytic support and address deficiencies in the implementation of Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall QIP, by: updating Fall Prevention Decision Trees and MLTSS Fall Prevention Database to allow easier input of data, resulting in increased reporting; Pilot the Otago Exercise Program in one of WellCare NJ's participating counties; continued review per IPRO PIP evaluation; Key QI and MLTSS staff to attend annual EQRO QIP/PIP Training; conduct quarterly analysis of data; Insures that key elements (interventions) can be operationalized before development and implementation; A QI Data Analyst and Sr. QI Project Manager with MA in Nursing Informatics and experience writing PIPs and CCIPs hired as of 1/2/2018 and will assist with interpretation and analysis of data.

- *The plan should improve the EI QIP data collection procedures by using systematic methodology to ensure validity and reliability, clear specifications of data sources, and demonstrate linkages between measurements and the interventions, as well as clarify timelines for data collection, analysis, and reporting.*

WellCare will review and correct deficiencies per IPRO PIP evaluation of the EI QIP. The plan will improve the data collection procedures by utilizing the specifications for the NJ Performance Measure: DEV_CH: Developmental Screening in the First Three Years of Life in place of chart reviews; each intervention will have measureable (numerator and dominator) outcomes; Key QI and MLTSS staff will attend annual EQRO QIP/PIP Training; conduct quarterly analysis of data will be conducted; Insure that key elements (interventions) can be operationalized before development and implementation; a QI data analyst and Sr. Project Manager will assist with interpretation and analysis of data.

- *The plan should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled General Population members.*

An enhanced initial health screening (IHS) outreach process for general population members to include the existing telephonic outreach with the addition of written correspondence.

A weekly new member report is generated to identify members that were not successfully engaged telephonically.

Members identified on the Unable to Contact report are mailed a paper Initial Health Screen for completion.

The initial health screening is included in the head of household kit mailed to all new members.

Rates of return for the paper IHS forms as well as the success of the telephonic outreach are monitored monthly.

- *The plan should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources. Attention to aggressive outreach efforts for the DCP&P population is also encouraged.*

1. WellCare Health Plans of NJ uses weekly reports to monitor outreach attempts by CM staff to engage members in CM. This reports tracks members that are UTC as well as those who refuse. Management staff reviews these reports and

identifies any instances where the aggressive outreach process was not followed. Any identified members without the appropriate attempts are sent back for additional outreach.

2. For those members that have been identified as High Risk/High Utilizers based upon their claims experience, or those that have been in care management but are not currently able to be contacted, WellCare has enlisted the assistance of Field Outreach Coordinator(s). The Field Outreach Coordinator is someone that is familiar with community resources, such as homeless shelters, soup kitchens and other locales/communities where our lost members may frequent. If members are found the Care Manager is made aware to outreach and complete the NJCNA.

3. CM Management reviews the Open CM non-MLTSS report weekly to ensure timely completion of CNA and care plans.

4. A Step Action document is used to clearly define aggressive outreach interventions for staff.

5. The ability to engage members in CM for the special populations such as those with chronic conditions or contract specific conditions is reviewed by a combined quality and health services team via the Population health Committee held 8 times annually in the market. The team reviews finding and helps develop strategies to improve the ability to connect and engage with these members.

- *The plan should focus on age-appropriate immunizations for the child and adult populations enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, DCP&P nurse should be consistently documented, including results of lead testing.*

1. The NJIIS system is utilized to obtain vaccination records on all pediatric cases. The primary care physician is contacted to verify and discuss gaps in preventative care. HEDIS Gaps are reviewed on all cases.

2. The presence of updated vaccine and immunization records are is part of what is audited monthly. Managers provide ongoing feedback to care managers that show deficiencies in this area for DDD, DCPP and the General Population.

3. Results of lead testing when indicated are documented in the care plan/case notes, as well as the WellCare lead test results database. Supervisors audit cases monthly to ensure documentation is completed according to established polices and step actions.

4. CMs are counselled by their supervisor when audit scores fall below expectations in this and all other areas

- *The plan should continue to ensure that dental needs are addressed for General Population members enrolled in CM, including documentation of the last visit date.*

WellCare will continue to add dental visit follow-ups and age appropriate immunizations (as indicated in recommendation #11) on all care plans opened for care management. This will continued to be monitored by management weekly via the open cases report as well as monthly audits.

WellCare CM Team will continue to collaborate with the Pharmacy department to identify members that have not had a dental claim for outreach and referral to a dentist.

All members that have been in the ER for dental concerns will continue to be assigned to a CM for outreach and education.

- *The plan should ensure the HCBS MLTSS members' plan of care is based on "person-centered" principals completed, signed and given to the member and/or authorized representative in a timely manner. Back-up plans should be reviewed and signed on a quarterly basis as appropriate. As part of ongoing care management, the plans of care should be completed on an annual basis in a timely manner. In addition, the care plan should be updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the*

member and/or authorized representative. File documentation should address training a member and/or representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation.

Plans of care:

1. Plans of care are reviewed and discussed in 1:1 case conferences between care managers and Managers/Supervisors to ensure that the goals of members' plans of care were developed using person-centered principles, completed timely and updated based on change in member condition.

2. Supervisors and managers random review charts to ensure care plan goals meet all required criteria. Care Managers that have care plans not meeting these standards will be re-educated as needed.

3. WellCare requires newly hired care managers to submit 100 of care plans for review at time of completion until manager or supervisor is satisfied with plan of care quality, including ensuring that care plan goals were developed using person-centered principles.

4. Two members are discussed at each individual care management team's monthly staff meeting, which includes discussing the quality of the plan of care to reinforce best practices in plan completion, including seeing examples of goals built using person-centered principles.

5. Newly hired care managers (under 3 months) are required to submit 100 of care plans for review at time of completion until their manager or supervisor is satisfied with plan of care quality, including ensuring that care plan goals were developed using person-centered principles.

6. Two members are discussed at each individual care management team's monthly staff meeting, which includes discussing the quality of the plan of care to reinforce best practices in plan completion, including seeing examples of goals built using person-centered principles.

7. Quarterly Care Management audits include a review of whether the Plan of Care goals included in selected review cases were developed using a member-centric approach demonstrating member involvement in development/modification, completed in a timely manner annually and updated based on change in member condition, including but not limited to facility discharges, signed and a copy provided to the member and/or authorized representative.

Back Up Plan:

1. WellCare uses standardized visit note templates to ensure required documentation for initial as well as ongoing visits are completed. These templates include an area for care managers to indicate whether a backup plan was completed.

2. WellCare includes the requirement for back up plans to be present and signed in its quarterly Care Management Audits. Any findings from these audits related to this requirement will be addressed by managers to identify areas of deficiency in need of targeted improvement efforts.

3. WellCare implemented a new Back-up Plan Report to capture each member's last back up plan update date. This report is sent to all MLTSS Care Management Managers monthly to review and follow-up with their individual care managers as needed.

4. WellCare identified one MLTSS Care Management Manager to take the lead on reviewing this report to identify trends by Care Manager and/or Care Manager Team in order to address individual care managers and/or teams that are not meeting this requirement.

Training a member and/or representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation:

1. WellCare tracks Critical Incidents and timely contact with the member via the Critical Incident Database and quarterly Care Management Audits.

2. WellCare's standardized note templates for initial and quarterly face-to-face visits includes an area for the care manager to indicate whether the member and/or their representative has been educated on Critical Incidents, knows when to contact their Care Manager and acknowledges understanding this information.

3. Care Management audits as well as 1:1 case conferences between Manager/Supervisor and Care Manager include a review of member education documentation on how to identify and report a Critical Incident including abuse, neglect and exploitation.

- *The plan should ensure copies of facility plans of care are on file and reviewed, participation in facility IDT meetings, timely onsite review of member placement and services, and members are present at all onsite visits in the MLTSS NF CM audit.*

1. WellCare routinely re-educates MLTSS staff at team meetings.

2. WellCare implemented a Nursing Facility care management team to provide a facility member specific focus.

3. A Nursing Facility team specific scorecard was created to focus on the requirements for this population including presence of the facility Plan of Care (POC) and member onsite visit which is put into a shared drive monthly for MLTSS Director review.

4. Nursing Facility team care managers request and review the facility POC at the time of initial member outreach and bi-annually (or whenever there is a change in condition or services) thereafter. Presence of the facility Plan of Care is tracked monthly by the MLTSS Manager/Supervisor using the facility team specific scorecard.

5. WellCare created a Nursing Facility specific visit note template which is specifically designed as a quarterly/semi-annual visit note to capture required documentation.

6. MLTSS Manager/Supervisor verify that an IDT is scheduled annually and monitor attendance during 1:1 case conferences via the CMs individual caseload report within the care management documentation system. The CM will provide evidence of annual attendance at the IDT at the time of the case conference by producing the IDT case note.

7. Compliance of above is monitored during 1:1 case conferences and monthly Care Management audits. Findings are used as a tool by Managers/Supervisors to identify deficiencies by care manager and target improvement efforts.

CHAPTER 5 – CONCLUSIONS AND RECOMMENDATIONS

This report has provided an overview of activities and findings for January 2018–December 2018. The following section provides a summary of MCO-specific strengths and opportunities for improvement.

ABHNJ

ABHNJ had an enrollment of 51,588 for Core Medicaid and MLTSS as of December 2018, which represented 3% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

ABHNJ's compliance score for 6 of 13 reviewed standards in the 2018 Annual Assessment of Operations Review was 100%.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2018 Annual Assessment of Operations Review.

For HEDIS PMs, the plan exceeded the 75th percentile for the Medication Management for People with Asthma (MMA) – Total – 50% Compliance rate.

In the Core Medicaid CM audit, ABHNJ scored above the 80% standard for all five categories (Identification, Outreach, Preventive Service, Continuity of Care, Coordination of Services) for all three populations (General, DDD, and DCP&P). ABHNJ scored 100% for Coordination of Services for the General, DDD, and DCP&P populations in 2017. The plan also scored 100% for Continuity of Care for the General and DCP&P populations, Identification for the DDD and DCP&P populations, and Outreach for the DDD population. The plan scored at or above 97% for five categories (Identification, Outreach, Preventive Service, Continuity of Care, Coordination of Services) for the DCP&P population.

In the 2018 MLTSS HCBS CM audit, ABHNJ scored above 90% for MLTSS PMs #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) and #16 (Member training on identifying/reporting critical incidents).

In the 2018 MLTSS NF CM audit, ABHNJ scored at or above 90% for MLTSS Plan of Care on File Includes Information from the Facility Plan of Care; Identification of Member for Transfer to HCBS; Plan of Care Addresses Formal and Informal Services; Member Present and Included in Onsite Visits; Coordination of Care; Completion of New Jersey Choice Assessment; Completion of PASRR Level I and Level II, if applicable, Prior to Transfer to an NF/SCNF; Communication of PASRR Level I; and Communication of PASRR Level II.

Opportunities for Improvement

ABHNJ scored below 50% compliance in 1 of the 14 standards in the 2018 Annual Assessment of Operations Review. ABHNJ received a compliance score of 40% for Efforts to Reduce Healthcare Disparities. ABHNJ scored 64% for Access and 84% for Programs for the Elderly and Disabled, which were below the 85% standard.

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

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

Based on the 2018 MLTSS HCBS CM audit, ABHNJ has opportunities for improvement in the following MLTSS PMs: PM#8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), PM#9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), PM#9a (Member's plan of care is

amended based on change of member condition), and PM#11 (Plans of care developed using "person-centered principles"), PM#12 (MLTSS HCBS plans of care that contain a back-up plan).

The plan has opportunities for improvement in the MLTSS NF CM audit to ensure copies of facility plans of care are on file and reviewed, participation in facility interdisciplinary team (IDT) meetings, and timely onsite review of member placement and services.

Recommendations

The plan should continue to monitor and evaluate disparities/barriers through the newly created Health Care Equity (HCE) Dashboard. The plan should continue to meet quarterly and address and identify healthcare disparities by continuous monitoring of interventions and outcomes in a timely manner. The plan should continue to address issues identified through analysis of disparities. The plan should continue to evaluate the effectiveness of its newly implemented action plan and consistently evaluate the process that monitors the plan's progress in reducing healthcare disparities.

The plan should continue to recruit pediatric PCPs and dental providers, and contract with hospitals to improve access to care in deficient counties.

The plan should continue to expand the MLTSS network to include at least two providers in every county for medical day services, social adult day care, and structural day program.

The plan should continue to focus on improving appointment availability for adult and pediatric PCPs as well as specialists for urology, general surgery, podiatry, and orthopedics.

The plan should develop a process to ensure providers receive member reports for aspiration pneumonia; injuries, fractures and contusions; decubiti; and seizure management. The plan should continue to monitor and evaluate the quarterly reports and implement processes and workflows for these conditions to ensure providers and care managers are appraised of the reporting data to continue to monitor, evaluate and improve member outcomes.

The plan should ensure all Core Medicaid member grievances as well as MLTSS provider grievances and MLTSS utilization management cases are handled timely.

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

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

The plan should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an individual health screen (IHS) for newly enrolled General Population members. The plan should also continue to ensure that timely and adequate attempts are made to reach members for completion of the comprehensive needs assessment (CNA) when potential CM needs are identified through completion of the IHS or other sources.

For all three groups (Groups C, D, and E) in the MLTSS HCBS CM audit, the MCO should ensure there is documentation to reflect a member-centric approach, which demonstrates involvement of the member in the development and modification to the agreed-upon goals; this includes that the member and member representative, as applicable, are reflected in the documentation as present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the POC. For Group C, the MCO should ensure that documentation includes a member rights and responsibilities statement tailored for the MLTSS member, signed by the member 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. For Group D, the MCO should ensure that a risk assessment is completed and includes documentation of whether a positive risk was identified or not (as well as indication of a positive risk requiring a risk management agreement) for members residing in their community home; additionally, the MCO should ensure that documentation includes a member rights and responsibilities statement tailored for the MLTSS member, signed by the member 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.

The plan should ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.

AGNJ

AGNJ had an enrollment of 177,498 for Core Medicaid and MLTSS as of December 2018, which represented 11% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

AGNJ's compliance score for 8 of 13 reviewed standards in the 2018 Annual Assessment of Operations Review was 100%.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2018 Annual Assessment of Operations Review.

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); Comprehensive Diabetes Care (CDC; rate for HbA1c Control [<7.0] for a Selected Population); Prenatal and Postpartum Care (PPC; rate for Timeliness of Prenatal Care); Immunizations for Adolescents (IMA; rates for Meningococcal; Tdap/Td; and Combination 1); Appropriate Testing for Children with Pharyngitis (CWP); Chlamydia Screening (CHL; rates for 21-24 Years and Total); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; rates for BMI percentile - 3-11 Years, 12-17 Years, Total; Counseling for Nutrition - 3-11 Years, 12-17 Years, Total; Counseling for Physical Activity - 3-11 Years, 12-17 Years, Total); Adult BMI Assessment (ABA); Children and Adolescents' Access to Primary Care Practitioners (CAP; rates for 25 Months - 6 Years and 7-11 Years); and Medication Management for People with Asthma (MMA; 50% Compliance rates for 5-11 Years, 12-18 Years, 19-50 Years, 51-64 Years, and Total).

In the Core Medicaid CM audit, AGNJ scored above the 80% standard for all five categories (Identification, Outreach, Preventive Service, Continuity of Care, Coordination of Services) for all three populations (General, DDD, and DCP&P). AGNJ scored 100% in Identification and Outreach for the DCP&P population as well as in Coordination of Services for the General Population.

In the 2018 MLTSS HCBS CM audit, AGNJ scored above 90% for MLTSS PM #16 (Member training on identifying/ reporting critical incidents).

In the 2018 MLTSS NF CM audit, AGNJ scored at or above 90% for Identification of Member for Transfer to HCBS; Plan of Care Addresses Formal and Informal Services; Completion of PASRR Level I and Level II, if applicable, Prior to Transfer to an NF/SCNF; Participation in an IDT Related to Transition; Authorization and Procurement of Transitional Services; Services Initiated upon Facility Discharge According to Plan of Care; and Documentation of Discussion with the Member Prior to Change of Service/Placement.

Opportunities for Improvement

AGNJ received a compliance score of 50% for Access in the 2018 Annual Assessment of Operations Review, which was below the 85% standard.

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

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

Based on the 2018 MLTSS HCBS CM audit, AGNJ has opportunities for improvement in the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), #11 (Plans of care developed using "person-centered principles"), and #12 (Plans of care contain a back-up plan).

The plan has opportunities for improvement in the MLTSS NF CM audit to ensure copies of facility plans of care are on file and reviewed, participation in facility IDT meetings, and timely onsite review of member placement and services.

Recommendations

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

The plan should continue to expand the MLTSS network to include at least two providers in every county for medical day services, social adult day care, structural day program, supported day services, adult family care, and TBI behavioral program.

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

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

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

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

For Group C in the MLTSS HCBS CM audit, the plan should ensure that a signed risk management agreement with all of its components is documented when a positive risk indicator requires a risk management agreement. For Group D, the MCO should ensure a member-centric approach demonstrates involvement of the member in the development and modification to the agreed-upon goals when applicable; this includes that the member and 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 POC. For Group C and Group D, the MCO should ensure a completed and signed initial POC is provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program and that goals in the initial POC meet the four criteria. For all three groups, the MCO should ensure that there is documentation of a completed and signed back-up plan using the State-mandated form.

The plan should ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.

HNJH

HNJH had an enrollment of 861,174 for Core Medicaid and MLTSS as of December 2018, which represented 53% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

HNJH's compliance score for 8 of 14 reviewed standards in the 2018 Annual Assessment of Operations Review was 100%.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2018 Annual Assessment of Operations Review.

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Immunizations for Adolescents (IMA; rates for Meningococcal, Tdap/Td, Combination 1); Children and Adolescents' Access to Primary Care Practitioners (CAP; rates for 12-24 Months; 25 Months - 6 Years; 7-11 Years; 12-19 Years); Medication Management for People with Asthma (MMA; 50% Compliance rates for 5-11 Years, 12-18 Years, 19-50 Years, 51-64 Years, Total); Annual Dental Visit (ADV; rates for 2-3 Years, 7-10 Years, 11-14 Years, 15-18 Years, 19-20 Years, Total); and Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC; 1-5 Years).

The plan's PIP submissions met overall compliance with the reviewed elements.

In the Core Medicaid CM audit, HNJH scored at or above 98% for all five categories (Identification, Outreach, Preventive Service, Continuity of Care, Coordination of Services) for the DCP&P population. HNJH also scored 100% in Coordination of Services for the General Population and Identification and Coordination of Services for the DDD population.

In the 2018 MLTSS HCBS CM audit, HNJH scored 100% for MLTSS PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) and above 90% for MLTSS PMs #12 (MLTSS Home and Community-Based Services [HCBS] plans of care that contain a back-up plan) and #16 (Member training on identifying/reporting critical incidents).

In the 2018 MLTSS NF CM audit, HNJH scored at or above 90% for Identification of Member for Transfer to HCBS; Plan of Care Addresses Formal and Informal Services; Member Present and Included in Onsite Visits; Coordination of Care; Completion of New Jersey Choice Assessment; and Documentation of Discussion with the Member Prior to Change of Service/Placement.

Opportunities for Improvement

HNJH received a compliance score of 80% for Efforts to Reduce Healthcare Disparities in the 2018 Annual Assessment of Operations Review, which was below the 85% standard.

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

In the 2018 Core Medicaid CM audit, the plan scored 72% for Outreach for the General Population, which was below the 80% standard.

Based on the 2018 MLTSS HCBS CM audit, HNJH has opportunities for improvement in the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annual within 30 days of the members anniversary and as necessary), and #11 (Plans of care developed using "person-centered principles).

The plan has opportunities for improvement in the MLTSS NF CM audit to ensure copies of facility plans of care are on file and reviewed, participation in facility IDT meetings, and timely onsite review of member placement and services.

Recommendations

The plan should implement ongoing evaluation of the action plan implemented in 2017 related to cancer screenings in Efforts to Reduce Healthcare Disparities.

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

The plan should develop chase-level action plans to ensure that all MRR occurs in a timely fashion to allow for hybrid measure reporting.

The plan should develop a comprehensive approach to the building and validation of the HEDIS Warehouse.

For the General Population in the Core Medicaid CM audit, the plan should ensure that ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members demonstrating potential care management needs.

For all three groups (Groups C, D, and E) in the MLTSS HCBS CM audit, the plan should ensure a member-centric approach demonstrates involvement of the member in the development and modification to the agreed-upon goals when applicable; this includes that the member and 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 POC. For Group C, the MCO should ensure documentation of the member rights and responsibilities statement are tailored for each MLTSS member, signed by the member 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.

The plan should ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.

UHCCP

UHCCP reported an enrollment of 467,877 for Core Medicaid and MLTSS as of December 2018, which accounts for 29% of the State's Medicaid and MLTSS managed care enrollment.

Strengths

UHCCP's compliance score for 6 of 13 reviewed standards in the 2018 Annual Assessment of Operations Review was 100%.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2018 Annual Assessment of Operations Review.

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Comprehensive Diabetes Care (CDC; rates for HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population); Controlling High Blood Pressure (CBP); Prenatal and Postpartum Care (PPC; rate for Timeliness of Prenatal Care); Immunizations for Adolescents (IMA; rates for Meningococcal, Tdap/Td, Combination 1); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; rates for BMI percentile - 12-17 Years, Counseling for Nutrition - 12-17 Years, Counseling for Physical Activity - 12-17 Years); Annual Monitoring for Patients on Persistent Medications (MPM; rates for ACE Inhibitors or ARBs, Total); Children and Adolescents' Access to Primary Care Practitioners (CAP; rates for 12-24 Months, 25 Months - 6 Years, 7-11 Years, 12-19 Years); Medication Management for People with Asthma (MMA; 50% Compliance rates for 5-11 Years, 12-18 Years, 19-50 Years, 51-64 Years, Total); Annual Dental Visit (ADV; rates for 4-6 Years, 7-10 Years, 11-14 Years, 15-18 Years, 19-20 Years, Total); Adults' Access to Preventive/Ambulatory Health Services (AAP; rate for 65+ Years).

In the Core Medicaid CM audit, all of UHCCP's rates for the DCP&P populations were at or above 90% in 2017. The plan scored 100% in Coordination of Services for the General Population, in Identification for the DDD population, and in Identification and Outreach for the DCP&P population.

In the 2018 MLTSS HCBS CM audit, UHCCP scored above 90% for MLTSS PMs #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), #12 (MLTSS Home and Community-Based Services [HCBS] plans of care that contain a back-up plan) and #16 (Member training on identifying/reporting critical incidents).

In the 2018 MLTSS NF CM audit, UHCCP scored at or above 90% for Identification of Member for Transfer to HCBS; Plan of Care Addresses Formal and Informal Services; and Coordination of Care.

Opportunities for Improvement

UHCCP received a compliance score of 79% for Access, 80% for Credentialing and Recredentialing, and 80% for Utilization Management in the 2018 Annual Assessment of Operations Review, which were below the 85% standard.

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

Review of the PIP submissions showed deficiencies related to analytic support and implementation for all Core Medicaid/ and MLTSS PIPs that were active at the end of the review period.

In the 2018 Core Medicaid CM audit, the plan scored 70% for Preventive Service for the General Population, which was below the 80% standard.

Based on the 2018 MLTSS HCBS CM audit, UHCCP has opportunities for improvement in the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annual within 30 days of the members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), and #11 (Plans of care developed using "person-centered principles).

The plan has opportunities for improvement in the MLTSS NF CM audit to ensure copies of facility plans of care are on file and reviewed, participation in facility IDT meetings, and timely onsite review of member placement and services.

Recommendations

The plan should continue to recruit pediatric specialists and contract with hospitals to improve access to care in the deficient counties.

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

The plan should follow the instructions provided to produce UM file universes and verify the universes submitted are following the specifications prior to submission.

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

The plan should review recredentialing dates for all MLTSS providers and ensure that the providers are recredentialed within three (3) years. The MCO should confirm and document that contracted providers are licensed to provide services in New Jersey.

The plan should ensure the Concurrent Review Report for Utilization Management is comprehensive and updated for the MCO's utilization for continuation and extension of services, as per contract requirements. The MCO should ensure the policies and procedures for concurrent review are adhered to by the MCO's employees. The MCO should utilize reports to meet contract timeframe requirements ensuring compliance, in particular, to meet the required timeframe of 24 hours for notification of determination involving continued/extended health care services.

The plan should continue to monitor and track determinations and written notifications of prior authorizations.

The plan should ensure that investigation of MLTSS grievances is adequately documented and the resolution letters to the member address the member's concern. The MCO should ensure that when pulling universes for review, the specifications are followed and the correct members are included in the file pull.

The plan should have a mechanism to track and monitor the appeal process and be able to produce a report that demonstrates compliance with the appeal process for UM determinations.

The plan should have a mechanism to track, monitor and report evidence of enrollee's receiving private duty nursing services and status of these enrollees.

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

The plan should continue to strengthen analytic support and address deficiencies in implementation for all Core Medicaid/MLTSS PIPs that were active at the end of the review period.

The plan should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

For all three groups (Groups C, D, and E) in the MLTSS HCBS CM audit, the plan should ensure a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals (which include that the member and/or member representative is present during the development of his/her goals, options are offered, that there is opportunity to express needs or preferences, and that needs or preferences were acknowledged and addressed in the POC). For Groups C and D, the MCO should ensure risk management agreements are signed and included with all components when there is positive indication of risk. For Group D, the MCO should ensure communication with the member's PCP in developing the care plan, and that goals meet all the criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals, 4- include a timeframe for the attainment of the desired outcome, and 5- be reviewed at a minimum during each visit and progress documented). For Group E, the MCO should ensure contact with the members' HCBS providers at least annually to discuss the providers' reviews of the members' needs and status, and quarterly for members receiving skilled nursing care, treatment for traumatic brain injury, or behavioral health services (for the necessary duration that members receive such services).

The plan should ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in IDT meetings and timely onsite review for member placement and services.

WCHP

WCHP reported an enrollment of 68,854 for Core Medicaid and MLTSS as of December 2018. This was 4% of New Jersey's Medicaid and MLTSS managed care enrollment.

Strengths

WCHP's compliance score for 10 of 14 reviewed standards in the 2018 Annual Assessment of Operations Review was 100%.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2018 Annual Assessment of Operations Review.

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Comprehensive Diabetes Care (CDC; rates for HbA1c Poor Control [>9.0%], HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population, Medical Attention for Nephropathy); Annual Monitoring for Patients on Persistent Medications (MPM; rates for ACE Inhibitors or ARBs, Diuretics, Total); Children and Adolescents' Access to Primary Care Practitioners (CAP; rates for 25 Months - 6 Years, 7-11 Years, 12-19 Years); Medication Management for People with Asthma (MMA; 50% Compliance rates for 5-11 Years, 12-18 Years, 19-50 Years, 51-64 Years, Total); Annual Dental Visit (ADV; rates for 2-3 Years, 11-14 Years); Asthma Medication Ratio (AMR; rate for 51-64 Years); and Adults' Access to Preventive/Ambulatory Health Services (AAP; rate for 65+ Years).

In the Core Medicaid CM audit, the plan scored above 90% for all categories (Identification, Outreach, Preventive Service, Continuity of Care, Coordination of Services) for the DDD and DCP&P populations. The plan scored 100% for Identification, Outreach, and Continuity of Care for the DDD population and for Identification and Coordination of Services for the DCP&P population.

In the 2018 MLTSS HCBS CM audit, WCHP scored above 90% for MLTSS PMs #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), #12 (MLTSS Home and Community-Based Services [HCBS] plans of care that contain a back-up plan) and #16 (Member training on identifying/reporting critical incidents).

In the 2018 MLTSS NF CM audit, WCHP scored at or above 90% for Identification of Member for Transfer to HCBS; Member Present and Included in Onsite Visits; and Communication of PASRR Level I

Opportunities for Improvement

WCHP received a compliance score of 50% for Access in the 2018 Annual Assessment of Operations Review, which was below the 85% standard.

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

Review of the PIP submissions showed deficiencies related to analytic support and implementation for all Core Medicaid/ and MLTSS PIPs that were active at the end of the review period.

In the 2018 Core Medicaid CM audit, the plan scored 77% for Preventive Service for the General Population, which was below the 80% standard.

Based on the 2018 MLTSS HCBS CM audit, WCHP has opportunities for improvement in the following MLTSS PMs: #8 (Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annual within 30 days of the members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), and #11 (Plans of care developed using "person-centered principles).

The plan has opportunities for improvement in the MLTSS NF CM audit to ensure copies of facility plans of care are on file and reviewed, participation in facility IDT meetings, and timely onsite review of member placement and services.

Recommendations

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

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

The plan should develop and maintain an MLTSS summary analysis by county showing the number of providers for each provider type in each county. The analysis should also indicate counties where all existing providers are already contracted.

The plan should work closely with the obstetrics and specialty providers to address the deficiencies in appointment availability.

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

The plan should continue to strengthen analytic support and address deficiencies in implementation for all Core Medicaid and MLTSS PIPs that were active at the end of the review period.

The plan should focus on age-appropriate immunizations for the child and adult populations enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

For all three groups (Groups C, D, and E) in the MLTSS HCBS CM audit, the plan should ensure a member-centric approach demonstrating involvement of the member in the development and modification to the agreed-upon goals (which include that the member and/or member representative is present during the development of his/her goals, options are offered, that there is opportunity to express needs or preferences, and that needs or preferences were acknowledged and addressed in the POC). Furthermore, for Group D, the MCO should ensure risk management agreements are signed and included with all components when there is positive indication of risk.

The plan should ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.