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

CORE MEDICAID and MLTSS QUALITY TECHNICAL REPORT

January 2019–December 2019

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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 2019. Enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long Term Services and Supports (MLTSS) was 1,586,799 as of 12/31/2019.

External quality review (EQR) activities conducted during January 2019–December 2019 included annual assessment of MCO operations, performance measure (PM) validation, performance improvement projects (PIPs), focus studies, DMAHS encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, Core Medicaid care management (CM) audits, and MLTSS CM Audits.

State Initiatives

The information for the state initiatives is provided by DMAHS.

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. DMAHS launched the Demonstration in July 2015, which was to conclude in June 2018, but the Demonstration was extended in budget language in both 2018 and 2019 for transitional purposes. A baseline report from year one of the Demonstration has been published. Legislation to transition the ACO Demonstration project to the Regional Health Hub Program (RHH) was signed into law on January 21, 2020. These RHHs will establish, operate, and maintain a health information platform that allows for population-level views and analytics and for patient-level health interventions. The RHHs will also function as conveners and collectors for community level stakeholder input within the RHHs core region.

Health Information Technology and the Medicaid Enterprise System

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

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid including the establishment of an overall Medicaid Enterprise System (MES) strategy encompassing IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E) and the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the Centers for Medicare & Medicaid Services (CMS) Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards.

Medicaid Management Information System

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

With guidance from CMS, DMAHS is currently modernizing the MMIS. The modernization strategy includes leveraging the current MMIS as the modernization platform by deploying enhancements to its existing functions and capabilities. In addition, the strategy is also to identify MMIS modules and processes that will be modernized, such as system integrator, drug rebate, and provider management. The new system, referred to as the MMIS Modernization (MMIS-M), 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.

NJ FamilyCare Integrated Eligibility System

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

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

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

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

In 2018, NJHelps was expanded to include a client portal. NJHelps client portal provides registered NJ FamilyCare applicants online access to application status, ability to upload required documentation, and secure electronic notices (e-notices). Additional FDSH enhancements, Verify Lawful Presence (VLP) to validate immigration status and SSA Title II to verify Social Security Income benefits were also developed and deployed in 2018.

Also in 2019, the NJ FamilyCare IES deployed Presumptive Eligibility and is currently implementing electronic Renewals and Redeterminations. In the coming year, New Jersey will transition from the Federal Facilitated Marketplace to a State Based Exchange. The NJ FamilyCare IES is currently being prepared and positioned to accommodate the expected increase in application processing and determination to make certain that health care benefits are available to those in need.

HITECH and the Promoting Interoperability Program

New Jersey continues to successfully govern and maintain adequate oversight of the Medicaid Promoting Interoperability Program. New Jersey's attestation portal has also been maintained and upgraded throughout the year as needed to keep up with the CMS guidelines for the program.

As of September 2019, New Jersey has completed the implementation for the projects related to enhancing the existing architectural and technical capabilities of NJHIN with the intent to advance State's interoperability efforts. The HITECH program will continue to support public health systems enhancements that allow providers to connect to registries to meet their clinical goals and requirements as well as to demonstrate Meaningful Use and receive incentive payments.

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

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

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

Medicaid Innovation Accelerator Program (IAP)

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

Community Based Care Management Demonstration

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

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

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

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

The MACCs (Medical Assistance Customer Centers), 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.

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.

2019 Annual Assessment of MCO Operations

For the review period July 1, 2018–June 30, 2019, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2019 compliance scores from the annual assessment ranged from 90% to 97%. Average compliance for five standards (Quality Assessment and Performance Improvement, Committee Structure, Satisfaction, Enrollee Rights and Responsibilities, and Utilization Management) remained the same from 2018 to 2019. Average compliance for six standards showed increases ranging from 1 to 8 percentage points for Access, Efforts to Reduce Healthcare Disparities, Programs for the Elderly and Disabled, Credentialing and Recredentialing, Administration and Operations, and Management Information Systems. In 2019, six standards (Quality Assessment and Performance Improvement, Committee Structure, Programs for the Elderly and Disabled, Satisfaction, Enrollee Rights and Responsibilities, and Management Information Systems) had an average score of 100%. Satisfaction was not subject to review for WCHP. Average compliance for three standards showed decreases ranging from 1 to 6 percentage points for Quality Management, Provider Training and Performance, and Care Management and Continuity of Care. In 2019, Access had the lowest average compliance score at 69%. During the onsite audit, IPRO conducted a full review of each MCO's private duty nursing (PDN) systems.

Performance Measures

2019 Core Medicaid Performance Measures

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

Overall, NJ weighted rates remained relatively constant between measurement year (MY) 2017 and MY 2018 (with a < 5 percentage point change year over year) for most measures. Significant increases (≥ 5 percentage point change) in performance from MY 2017 to MY 2018 were noted for one or more rates of the Appropriate Testing for Children with Pharyngitis (CWP), Follow-up After Emergency Department Visit for Mental Illness (FUM), and Medication Management for People with Asthma (MMA) measures. Significant decreases (≥ 5 percentage point change) in performance from MY 2017 to MY 2018 were noted for one or more rates of the Comprehensive Diabetes Care (CDC), Controlling High Blood

Pressure (CBP), the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Adult BMI Assessment (ABA), Follow up care for children prescribed ADHD medication (ADD), Use of Opioids from Multiple Providers (UOP).

2019 New Jersey State-Specific Performance Measures and Core Set Measures

As more patients with disabilities and chronic conditions transition to managed care from 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.

One Adult Core Set Measure: Diabetes Short-Term Complications Admission Rate (PQI01-AD) was added to MY 2018 and is defined by two age groups 18–64 years, and 65 years and older. In addition, one CHIPRA Core Set measure, Developmental Screening (DEV-CH) was reported by the MCOs. This measure is defined by age groups: 1 year old, 2 year old, and 3 year old.

2019 MLTSS Performance Measure Validation

During July 1, 2017–June 30, 2018, 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 2018–June 2019 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: MLTSS Members Receiving MLTSS Services; #21: MLTSS Members Transitioned from NF to Community; #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 and #29: All-Cause Readmissions of MLTSS Members to Hospital Within 30 days; #30 and #31: Emergency Department 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 MLTSS 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; #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members; and #46: MLTSS HCBS Members not Receiving MLTSS HCBS, PCA or Medical Day Services.

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 2019 reports ran through February 2020, which is outside the scope of this report.

IPRO worked with DMAHS to develop the specifications for the following measures in the 4th quarter of 2019 for the July 2019–June 2020 measurement period:

- #20a: New MLTSS Members with MLTSS Services Within 120 Days of Enrollment;
- #47: Post Hospitalization Institutional Care for MLTSS HCBS Members;

Also, following the release of NCQA's *Rules for Allowable Adjustments of HEDIS 2020*, IPRO worked with DMAHS to ensure that HEDIS-based measures followed the NCQA guidance. For the upcoming year, 2020 specifications directed the MCOs to produce the following measures following HEDIS methodology and reporting the unmodified HEDIS measure for the MLTSS subpopulations of interest:

- #48, #49: HEDIS Hospitalization for Potentially Preventable Complications (HPC);
- #50, #51: HEDIS Follow-up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC); and
- #52, #53: HEDIS Care for Older Adults (COA).

2019 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, 2018–June 30, 2019, 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 (black-out periods). A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and black-out period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2018 and June 30, 2019.

The MLTSS services assessed in this methodology were: Adult Family Care, Assisted Living Services/Program, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly Monitoring, PCA/Home Based Supportive Care, PERS Monitoring, Private Duty Nursing, Structured Day Program, and Supported Day Services.

Core Medicaid/MLTSS Performance Improvement Projects

For January 2019–December 2019, this QTR includes IPRO's evaluation of the April 2019 PIP updates, August 2019 PIP report submissions, and the Fall 2019 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

Non-clinical Focused Study Pharmacy Claims vs. Encounter Data

In 2019, the EQRO has initiated a pharmacy audit study with the Core Medicaid and Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) MCOs and EDMU. The objective of the audit is to verify the accuracy of pharmacy encounter data, including payment amounts, submitted to DMAHS by all five NJ Medicaid MCOs. The pharmacy encounter data submitted to DMAHS will be reconciled to the corresponding source claim data from the originally adjudicated claims paid to the pharmacies and differences will be identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018; the EQRO has selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Medicaid MCO. The MCOs have provided the adjudicated claim information and the EQRO is in the process of identifying the discrepancies. The review is underway and the EQRO is working closely with the MCOs and EDMU to complete the audit study in 2020.

2019 Maternal Mortality Focused Study

In 2019, at the request of DMAHS, IPRO began developing a clinical focused study on maternal mortality. This study aims to investigate pregnancy-associated deaths in the New Jersey Medicaid population and explore the predictors of maternal mortality. For the purposes of this study, pregnancy-associated death will be defined as death of a woman within 1 year of the termination of a pregnancy (excluding those terminated by elective abortion). This study is a retrospective cohort study of Medicaid-enrolled women who died in 2017 and 2018 within one year of the termination of a pregnancy that occurred while the woman was enrolled in New Jersey Medicaid. Because of the anticipated small population of focus, statistical comparisons to the general maternal population will not be conducted. The focused study is currently ongoing, and findings will be presented to DMAHS in 2020.

2019 CAHPS Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide Children's Health Insurance Program (CHIP) only survey. All of the members surveyed required continuous enrollment from July 1, 2018 through December 31, 2018, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey.

Care Management Audits

2019 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 2018 rates across all MCOs, populations, and categories ranged from 51% to 100%. Scores for the Identification category ranged from 58% to 100% across all MCOs for all populations (GP, DDD, DCP&P). Scores for Outreach ranged from 57% to 100% for all MCOs for all populations. Scores for the Preventive Services Category ranged from 51% to 100% across all MCOs for all populations. Scores for Continuity of Care ranged from 64% to 100% across all MCOs for all populations. Scores for Coordination of Services ranged from 81% to 100% across all MCOs for all populations.

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 across all populations and across five plans that were comparable

to 2017 (75 in total), eighteen (18) scored higher, eighteen (18) remained the same, and thirty-nine (39) scored lower in 2018.

2019 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 7/1/2018 through 6/30/2019. The results from the previous review period (7/1/2017–6/30/2018) were compared to the 2019 audit, which includes the new results from 7/1/2018–6/30/2019.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 45 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contracts (Article 9) dated July 2018 and January 2019. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

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 7/1/18 and 1/1/19 (Group C) and existing MMC members enrolled in MLTSS between 7/1/18 and 1/1/19 (Group D), the 2019 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/18) and continuously enrolled with the MCO in MLTSS through 6/30/19. 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 7/1/2018 to 6/30/2019 audit results for Groups C, D and E ranged from 52.9% for PM #11 Plans of Care developed using "person-centered principles," to 97.8% for PM #10 Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment.

2019 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 7/1/2017 through 6/30/2018. IPRO prepared an audit tool based on the DMAHS MCO Contracts (Article 9) dated July 2017 and January 2018. The audit tool was 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.

All five MCOs scored at or above 98% for "MLTSS Plans of Care on file" and all MCOs scored at or above 97% for "Members present at each onsite visit." All five MCOs scored at or above 86% for "Members identified for transfer to HCBS." Three MCOs scored at or above 95% for "Member and/or representative participated in the development of goals." Four MCOs scored at or above 89% for "New Jersey Choice Assessment completed during the review period." Four MCOs scored at or above 88% for "Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to transfer to NF/SCNF."

Four MCOs have an opportunity for improvement in the following elements: care manager's participation in at least one facility interdisciplinary team (IDT) meeting (scores ranged from 11% to 75%); copies of any facility plans of care on file

(scores ranged from 66% to 79%); and documented review of the facility plan of care (scores ranged from 37% to 79%). Three MCOs have an opportunity for improvement in the following element: completion of initial plan of care (scores ranged from 9% to 27%).

Only one MCO had a member that fell in the "Members who transitioned from a NF/SCNF to HCBS"; therefore, a comparison could not be made across MCOs. The MCO 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 2019 through December 2019.

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 2019, there were approximately 1,586,799 individuals enrolled in MMC and the number decreased from 1,626,991 in December 2018 (**Table 1**). Of the 1,586,799 individuals enrolled in MMC, 53,523 were receiving MLTSS services as of December 2019. More than 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 53,523 as of December 2019 (**Table 1**).

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in January 2019–December 2019. **Table 1** presents respective enrollment figures in December 2018 and December 2019.

Table 1: 2018–2019 MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2018	December 2019	December 2018	December 2019
Aetna Better Health of New Jersey	ABHNJ	51,588	65,643	3,099	3,806
Amerigroup New Jersey, Inc.	AGNJ	177,498	187,882	7,167	8,315
Horizon NJ Health	HNJH	861,174	841,457	19,411	20,893
UnitedHealthcare Community Plan	UHCCP	467,877	418,378	9,113	9,901
WellCare Health Plans of New Jersey, Inc.	WCHP	68,854	73,439	8,585	10,608
Total		**1,626,991**	**1,586,799**	**47,375**	**53,523**

[1]Managed Long Term Services and Supports (MLTSS) members are included in the December 2018–2019 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 2018 and December 2019 in relation to the entire NJ MMC population.

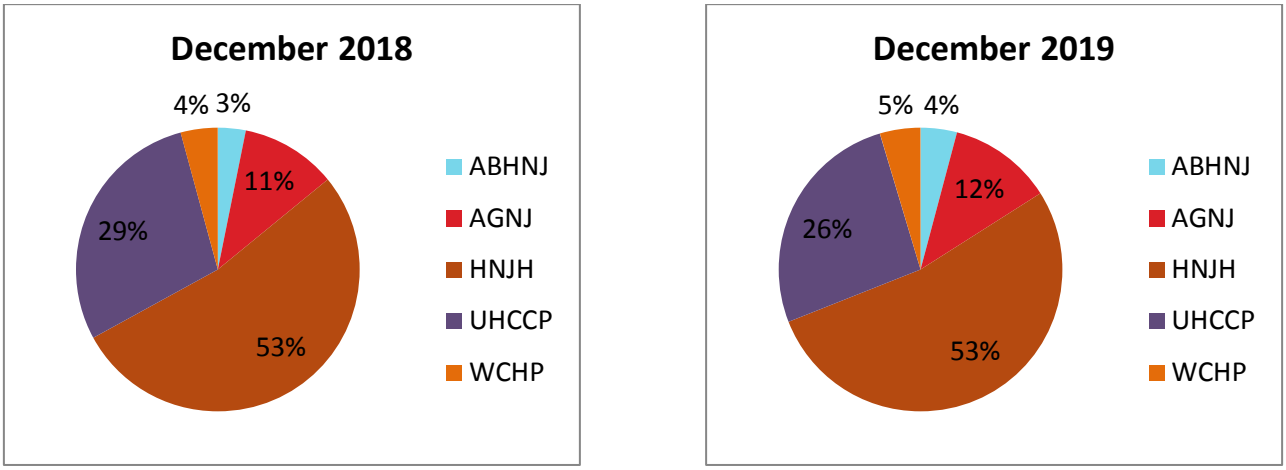

Figure 1: 2018–2019 Medicaid Managed Care Enrollment by MCO. Enrollment in MMC for each MCO reported in **Table 1** as of December 2018 (left panel) and December 2019 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (light blue); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (brown); 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: 2019 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 2019 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 is currently conducting one clinical focused study and one non-clinical focused study, and fielded the 2019 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 2019 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 in budget language in both 2018 and 2019 for transitional purposes. A baseline report from year one of the Demonstration has been published. Legislation to transition the ACO Demonstration project to the Regional Health Hub Program (RHH) was signed into law on January 21, 2020. These RHHs will establish, operate, and maintain a health information platform that allows for population-level views and analytics and for patient-level health interventions. The RHHs will also function as conveners and collectors for community level stakeholder input within the RHHs core region.

Health Information Technology and the Medicaid Enterprise System

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

As with other state Health and Human Service (HHS) agencies, DMAHS is undergoing changes to modernize Medicaid including the establishment of an overall Medicaid Enterprise System (MES) strategy encompassing IT projects in the Medicaid Management Information System (MMIS), Eligibility & Enrollment (E&E) and the Health Information Technology for Economic and Clinical Health (HITECH). The MES is intended to align in the vision and mission of the program, have a comprehensive strategy and governance, implement rigorous controls around quality and risk management, streamline procurement and shared services, drive digital enablement such as user interfaces and user experience, and understand and react to organizational change. DMAHS aims to implement projects utilizing agile methodology that is able to respond to program needs and aligns with the federal goals and the Medicaid Information Technology Architecture (MITA) framework. As such, the systems will be developed to fully comply with the CMS Seven Conditions and Standards for modularity, interoperability, MITA, business results, reporting, leveraging, and use of industry standards. This will help DMAHS achieve the dual goals of obtaining enhanced match funding, and the successful development and deployment of a modern information system. A more adaptable design will better position NJ's Medicaid Enterprise for the future, and provide the ability to more quickly address Medicaid program needs.

Medicaid Management Information System

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

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

NJ FamilyCare Integrated Eligibility System

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

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

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

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

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

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

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

HITECH and the Promoting Interoperability Program

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

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

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

In 2019, in support of the SUD 1115 demonstration waiver, the HITECH program also operationalized the State-funded Substance Use Disorder Promoting Interoperability Program (SUD PIP) to enable SUD providers to utilize the EHR

systems to improve data access and increase interoperability between physical and behavioral health providers. An SUD HIT workgroup was formed to administer and oversee this program including tracking of incentive payments to SUD providers and meaningful utilization of appropriate electronic health record systems. New Jersey was one of the only states that successfully launched and operationalized the SUD Promoting Interoperability program; CMS invited New Jersey to present in national conferences and webinars to share these efforts and strategies with other interested states.

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

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

Medicaid Innovation Accelerator Program (IAP)

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

Value Based Payment and Financial Simulations:

Under the Value Based Payment (VBP) and financial simulation IAP, selected states received technical support if 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).

New Jersey chose to explore a bundled payment approach to VBP within their Managed Care Organization (MCO) program. The New Jersey (NJ) initiative involved a bundled payment arrangement for pediatric asthma services provided to MCO enrollees, which is modeled on Tennessee Medicaid's bundled payment program for acute asthma exacerbations.

At the conclusion of the technical assistance, a final report was submitted to NJ. It was evident from the results that NJ's data system has sufficiently comprehensive and detailed claims and enrollment records to support a bundled payment VBP approach within their MCO program if the State chooses to pursue it. The TA concluded in September 2018.

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

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

The one-on-one technical support program included peer-to-peer learning opportunities and tailored coaching focused on two key objectives:

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

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

A Scope of Work for a VBP initiative was created by the EQRO during 2019 which incorporated MLTSS Performance measures from our HCBS care management audit in addition to PM #13 – MLTSS/HCBS services are delivered in accordance with the Plan of Care, including the type, scope, amount, frequency, and duration. Feedback on the Scope of Work was offered by the coaching team and incorporated into the EQRO'S Scope of Work for this initiative. The TA for the VBP for HCBS ended in July 2019. The HCBS VBP initiative remains under consideration as an incentive for the MCOs.

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

NJ participated in the Medicaid IAP for the Opioid Data Analytics Cohort that ran from April 2018 through September of 2018. The focus of the IAP was to look at Opioid Use Disorder (OUD) within the state Medicaid population, assess the availability and utilization of Medication Assisted Treatment (MAT) within the Medicaid program, and to assess the size and characteristics of Neonatal Abstinence Syndrome (NAS) and opioid related maternity care within the state Medicaid program.

Through the State participation in the Opioid data analytics work, NJ was able to identify areas to increase access and utilization of MAT. NJ utilized the data to determine the need to increase the number of waivered prescribers, incentivize rates to promote waivered prescriber participation in Medicaid, and to enhance the services physician practices can provide. The State developed an Office Based Addictions Treatment (OBAT) program that has expanded options for individuals in need of services in NJ by increasing the number of waivered prescribers, incentivizing rates to promote waivered prescriber participation in Medicaid, and enhancing the services physician practices can provide. The addition of navigation services in physician practices offer the beneficiary better support of psychosocial needs and follow up care for individuals receiving MAT. Two University Hospital programs were established as Centers of Excellence to initially train new prescribers and to provide ongoing support to prescribers throughout the state with availability of a hotline for questions and concerns related to treatment of OUD. The TA concluded in August 2018.

Community Based Care Management Demonstration

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

In the collaborative discussions with the MCOs, the Office of Quality Assurance (OQA) found that the commonalities of each MCO's CBCM program include aggressive outreach within the community to locate and engage members with high needs. Depending on the member's circumstances, a face-to-face assessment or in-person meeting may occur.

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

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

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

outcomes, helping states prioritize quality improvement initiatives, engage in thoughtful decision making, and conduct futures planning with valid and reliable LTSS data.

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

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

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

The MACCs (Medical Assistance Customer Centers), 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.

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

CHAPTER 3 – SUMMARY OF KEY FINDINGS

This chapter provides a review of key findings from January 2019–December 2019 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.

2019 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.

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.

Beginning in 2019, the Annual Assessment schedule began a three-year audit cycle program. This will allow for certain elements to be reviewed on a cyclical basis once every three years unless that element fails to meet the requirement for that review period. However, if an MCO receives compliance score less than 85%, it will result in a full audit the following year. The State has identified a set of Core Medicaid and MLTSS elements that will be subject to review annually regardless of Met/Not Met status in the prior year's review. 2019 included a full review of ABHNJ, AGNJ, HNJH, and UHCCP, as they underwent a partial review in 2018. WCHP had a partial review in 2019, as it had a full review in 2018. With the exception of WCHP, this review evaluated each health plan on 14 standards based on contractual requirements (total of 235 elements). The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2019 is outlined in **Table 4**.

Table 4: 2019 Annual Assessment Type by MCO

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

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 2019, two (2) elements in Utilization Management (UM4 and UM21) were removed from the Annual Assessment requirements. 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, 2018 to June 30, 2019.

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 PDN systems. Each MCO was required to present a live demonstration of the processes and flow of their PDN system and mechanisms used to track the NJ FamilyCare MMC enrollees receiving PDN services.

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

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

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

Summary of Comparative Results

Table 5 displays a comparison of the overall compliance score for each of the five MCOs from 2018 to 2019. For the review period July 1, 2018–June 30, 2019, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2019 compliance scores from the annual assessment ranged from 90% to 97% (**Table 5**). ABHNJ's compliance score increased from 91% to 93% in 2019, and WCHP's compliance score increased from 96% to 97%; AGNJ's compliance score remained at 95%; and HNJH and UHCCP compliance scores decreased by 2 and 3 percentage points to 95% and 90%, respectively (**Table 5**). One standard (Quality Management) decreased 6 percentage points from an average compliance score of 94% in 2018 to 88% in 2019 (**Table 6**). One standard (Care Management and Continuity of Care) decreased 4 percentage points from 97% in 2018 to 93% in 2019 (**Table 6**). Average compliance for five standards

[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.

(Quality Assessment and Performance Improvement, Committee Structure, Satisfaction, Enrollee Rights and Responsibilities, and Utilization Management) remained the same from 2018 to 2019. Average compliance for six standards showed increases ranging from 1 to 8 percentage points for Access, Efforts to Reduce Healthcare Disparities, Programs for the Elderly and Disabled, Credentialing and Recredentialing, Administration and Operations, and Management Information Systems (**Table 6**). In 2019, six standards (Quality Assessment and Performance Improvement, Committee Structure, Programs for the Elderly and Disabled, Satisfaction, Enrollee Rights and Responsibilities, and Management Information Systems) had a score of 100%. Satisfaction was not subject to review during the partial review for WCHP. Average compliance for three standards showed decreases ranging from 1 to 6 percentage points for Quality Management, Provider Training and Performance, and Care Management and Continuity of Care. In 2019, Access had the lowest average compliance score at 69% (**Table 6**).

Table 5: Comparison of 2018 and 2019 Compliance Scores by MCO

MCO	2018 Compliance %	2019 Compliance %	% Point Change from 2018 to 2019
ABHNJ	91%	93%	+2
AGNJ	95%	95%	0
HNJH	97%	95%	-2
UHCCP	93%	90%	-3
WCHP	96%	97%	+1

Table 6: 2018 and 2019 Compliance Scores by Review Category

Review Category[1]	MCO Average 2018[2]	MCO Average 2019[2]	Percentage Point Change
Access	67%	69%	+2
Quality Assessment and Performance Improvement	100%	100%	0
Quality Management	94%	88%	-6
Efforts to Reduce Healthcare Disparities	84%	92%	+8
Committee Structure	100%	100%	0
Programs for the Elderly and Disabled	96%	100%	+4
Provider Training and Performance	96%	95%	-1
Satisfaction	100%	100%	0
Enrollee Rights and Responsibilities	100%	100%	0
Care Management and Continuity of Care	97%	93%	-4
Credentialing and Recredentialing	94%	96%	+2
Utilization Management	92%	92%	0
Administration and Operations	97%	98%	+1
Management Information Systems	99%	100%	+1
TOTAL	**94%[3]**	**94%[3]**	**0**

[1] Satisfaction was not subject to review in 2019 for WCHP.
[2] MCO Average is the average of the compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP).
[3] Total is the average of compliance scores listed in **Table 5**.

Figure 2 depicts compliance scores since 2017. Compliance scores for five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) have remained at or above 90% for all three years. ABHNJ's compliance score has increased each year since 2017. WCHP's compliance score increased to above 90% in 2017 and remained above 90% in 2018 and 2019.

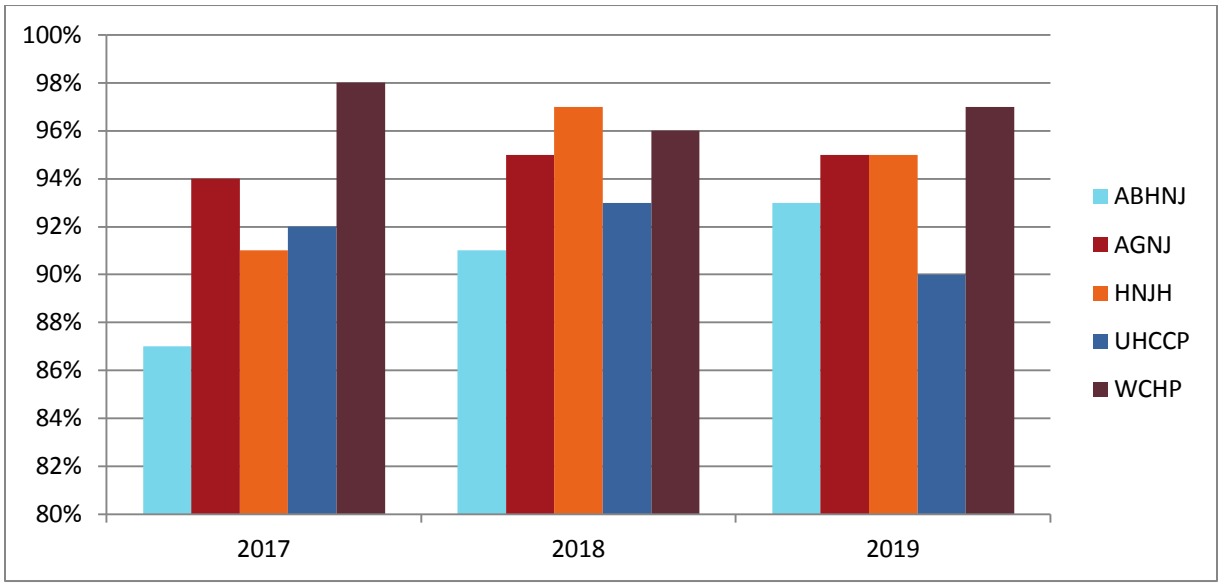

Figure 2: MCO Compliance Scores by Year (2017–2019). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, light blue); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, orange), UnitedHealthcare Community Plan (UHCCP, blue); and WellCare Health Plans of New Jersey, Inc. (WCHP, burgundy) are shown for 2017–2019.

During the onsite audit, IPRO conducted a full review of each MCO's PDN systems. Each MCO was required to present a live demonstration of the processes and flow of their PDN system and mechanisms used to track the NJ FamilyCare MMC enrollees receiving PDN services. ABHNJ and UHCCP had deficiencies regarding their PDN processes. ABHNJ does not have a formal or structured approach to ensuring that PDN cases are monitored and assessed and is currently relying on the low case load and individual care managers' familiarity with the individual cases. In addition, ABHNJ did not offer reports or policies to support any decisions to continue, reduce or increase PDN hours. UHCCP did not provide evidence of mechanisms used to track enrollees receiving PDN services for the review period. In addition, the report provided by UHCCP listing PDN cases was not accurate with regard to terminated PDN services.

The remaining three MCOs (AGNJ, HNJH and WCHP) provided a well-documented presentation of the management of PDN cases for MLTSS and non-MLTSS members. Their care management staff demonstrated knowledge of each case and provided clinical rationales for all changes in PDN services. Policies relating to PDN were provided for review. Ongoing monitoring and evaluation of the members receiving PDN was evident.

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 2019 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:

- Continue efforts in provider recruitment and improving access to hospitals, dental services, and primary care provider (PCPs) in all counties including access to and coverage of out-of-network services as necessary;
- Continue to expand the MLTSS network to include at least two providers in every county;
- Continuing to focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers;
- Implement planned interventions in a timely manner to have an effective impact on the outcome of the PIPs;
- Continue to strengthen analytic support and address deficiencies in implementation of the PIPs;
- Continue to evaluate and track caseloads to ensure care manager caseloads are not exceeding the weighted caseload limit;
- Develop a comprehensive approach to ensure applicable performance measure documentation is submitted correctly and timely;
- Ensure timely resolution of member and provider grievances and appeals; and
- Continue 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.

2019 Performance Measures

2019 Core Medicaid Performance Measures

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

Background

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

Assessment Methodology

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

Evaluation Findings

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP); four of the five MCOs demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State. ABHNJ did not include two measures in their certified HEDIS audit: Risk of Continued Opioid Use (COU) and Plan All-Cause Readmissions (PCR). These measures were not reported by the plan. ABHNJ's restated rates can be found in the Appendix. Following review of the submissions, ABHNJ submitted

rates for these measures which were reviewed and approved by a certified HEDIS compliance auditor (CHCA) at IPRO. These rates are not included in the statewide HEDIS grid as they were not submitted as audited HEDIS rates.

The following should be considered for valid interpretation and comparison of reported rates: AGNJ and HNJH; 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). HNJH chose not to include their FIDE SNP members in the HEDIS submission this year.

The following results were noted for the NJ Medicaid average (weighted rates). Overall, rates remained relatively constant between MY 2017 and MY 2018 (with a < 5 percentage point change year over year) for most measures. Significant increases and decreases (≥ 5 percentage point change) in performance from MY 2017 to MY 2018 are noted below.

Improvements in performance from MY 2017 to MY 2018:

- Appropriate Testing for Children with Pharyngitis (CWP) improved by 5.12 percentage points.
- Follow-up After Emergency Department Visit for Mental Illness (FUM)
  - 30-Day Follow-up improved by 7.30 percentage points.
  - 7-Day Follow-up improved by 8.04 percentage points.
- Medication Management for People With Asthma (MMA)
  - 5-11 Years - 50% Compliance improved by 5.76 percentage points.
  - 12-18 Years - 50% Compliance improved by 5.07 percentage points.
  - 5-11 Years - 75% Compliance improved by 6.09 percentage points.
  - 19-50 Years - 75% Compliance improved by 7.00 percentage points.
  - 51-64 Years - 75% Compliance improved by 5.85 percentage points.
  - Total - 75% Compliance improved by 6.28 percentage points.

Decreases in performance from MY 2017 to MY 2018:

- Comprehensive Diabetes Care
  - Blood Pressure Controlled < 140/90 mmHg decreased by 11.02 percentage points.
- Controlling High Blood Pressure (CBP) decreased by 12.55 percentage points.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
  - BMI percentile - 12-17 Years decreased by 9.61 percentage points.
  - Counseling for Nutrition - 12-17 Years decreased by 6.86 percentage points.
  - Counseling for Physical Activity - 12-17 Years decreased by 7.72 percentage points.
- Adult BMI Assessment (ABA) decreased by 8.06 percentage points.
- Follow up Care for Children Prescribed ADHD Medication
  - Continuation and Maintenance Phase decreased by 5.10 percentage points.
- Use of Opioids From Multiple Providers (UOP) (Higher rates for UOP indicate poorer performance)
  - Multiple Prescribers increased by 5.20 percentage points.

Table 7: 2019 HEDIS Performance Measures

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Childhood Immunization (CIS)					
Combination 2	63.26%	71.78%	72.02%	62.77%	66.67%
Combination 3	58.64%	67.15%	63.99%	56.20%	61.07%
Combination 9	34.31%	41.85%	35.77%	31.39%	34.79%
Lead Screening in Children (LSC)	67.64%	73.24%	74.70%	80.29%	80.05%

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	61.80%	69.34%	60.82%	62.53%	65.59%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)[1]	72.92%	78.52%	79.73%	76.16%	79.20%
Adolescent Well-Care Visits (AWC)	50.12%	64.48%	62.56%	60.58%	61.31%
Breast Cancer Screening (BCS)	42.95%	53.28%	57.56%	60.73%	59.89%
Cervical Cancer Screening (CCS)	43.07%	61.31%	63.57%	63.99%	48.66%
Comprehensive Diabetes Care (CDC)					
HbA1c Testing	84.41%	86.57%	84.91%	88.76%	90.36%
HbA1c Poor Control (>9.0%)[2]	36.20%	30.02%	38.94%	33.43%	33.80%
HbA1c Control (<8.0%)	51.43%	59.04%	53.00%	56.18%	56.15%
HbA1c Control (<7.0%) for a Selected Population	37.71%	44.87%	37.71%	39.73%	45.26%
Eye Exam	37.46%	58.37%	60.03%	63.62%	60.20%
Medical Attention for Nephropathy	92.47%	90.55%	89.54%	90.87%	93.16%
Blood Pressure Controlled <140/90 mm Hg	55.20%	64.51%	46.14%	61.24%	65.08%
Controlling High Blood Pressure (CBP)	59.37%	63.02%	43.07%	58.88%	60.34%
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	77.86%	88.68%	77.39%	86.62%	80.00%
Postpartum Care	54.74%	67.12%	55.53%	65.69%	55.44%
Immunizations For Adolescents (IMA)					
Meningococcal	83.52%	89.29%	91.97%	89.05%	84.18%
Tdap/Td	86.89%	94.89%	96.11%	93.19%	92.21%
HPV	20.22%	29.20%	36.98%	29.93%	31.63%
Combination 1	80.15%	88.56%	91.48%	88.32%	82.24%
Combination 2	17.98%	27.49%	35.77%	28.71%	26.52%
Appropriate testing for children with pharyngitis (CWP)	82.27%	91.28%	77.11%	87.01%	77.56%
Chlamydia Screening (CHL)					
16-20 Years	57.98%	61.86%	57.15%	58.62%	60.24%
21-24 Years	64.44%	69.91%	68.56%	62.70%	67.87%
Total	61.75%	65.26%	61.89%	60.38%	63.68%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile - 3-11 Years	86.50%	88.72%	73.66%	80.00%	82.46%
BMI percentile - 12-17 Years	81.02%	91.03%	73.81%	66.67%	83.69%
BMI percentile - Total	84.67%	89.54%	73.72%	75.43%	82.89%
Counseling for Nutrition - 3-11 Years	85.04%	84.59%	72.84%	77.41%	71.27%
Counseling for Nutrition - 12-17 Years	83.21%	84.14%	67.86%	71.63%	72.34%
Counseling for Nutrition - Total	84.43%	84.43%	70.80%	75.43%	71.64%
Counseling for Physical Activity - 3-11 Years	76.64%	78.95%	64.61%	68.15%	63.06%
Counseling for Physical Activity - 12-17 Years	82.48%	82.76%	66.07%	63.12%	69.50%
Counseling for Physical Activity - Total	78.59%	80.29%	65.21%	66.42%	65.28%
Adult BMI Assessment (ABA)	81.75%	96.27%	79.85%	85.40%	95.92%
Follow up care for children prescribed ADHD medication (ADD)					
Initiation Phase	33.33%	33.44%	31.02%	37.23%	40.98%
Continuation and Maintenance Phase	N/A	35.34%	32.66%	43.49%	N/A
Follow-up after hospitalization for mental illness (FUH)[3, 4]					
6-17 Years - 30-Day Follow-up	N/A	N/A	28.57%	N/A	N/A
6-17 Years - 7-Day Follow-up	N/A	N/A	5.71%	N/A	N/A
18-64 Years - 30-Day Follow-up	25.00%	46.88%	23.37%	34.40%	31.82%

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
18-64 Years - 7-Day Follow-up	13.64%	25.00%	10.87%	16.71%	15.91%
65+ Years - 30-Day Follow-up	N/A	N/A	N/A	28.57%	N/A
65+ Years - 7-Day Follow-up	N/A	N/A	N/A	16.07%	N/A
30-Day Follow-up	23.40%	47.37%	24.20%	33.61%	34.31%
7-Day Follow-up	12.77%	26.32%	10.05%	16.18%	15.69%
Follow-up After Emergency Department Visit for Mental Illness (FUM)[3,4]					
6-17 Years - 30-Day Follow-up	N/A	82.35%	75.59%	68.42%	N/A
6-17 Years - 7-Day Follow-up	N/A	58.82%	63.78%	59.16%	N/A
18-64 Years - 30-Day Follow-up	58.18%	61.90%	63.97%	59.76%	66.18%
18-64 Years - 7-Day Follow-up	41.82%	46.43%	51.04%	47.57%	54.41%
65+ Years - 30-Day Follow-up	N/A	N/A	N/A	41.51%	N/A
65+ Years - 7-Day Follow-up	N/A	N/A	N/A	35.85%	N/A
30-Day Follow-up	59.20%	67.80%	66.49%	62.05%	58.44%
7-Day Follow-up	43.20%	50.00%	53.83%	51.13%	48.05%
Annual Monitoring for Patients on Persistent Medications (MPM)					
ACE Inhibitors or ARBs	84.89%	89.50%	89.13%	91.66%	94.22%
Diuretics	82.17%	88.37%	88.76%	90.96%	93.59%
Total	83.81%	89.05%	88.98%	91.38%	93.98%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
12-24 months	93.21%	96.86%	96.40%	97.24%	95.27%
25 months - 6 years	88.65%	91.72%	93.00%	93.58%	91.79%
7-11 years	87.44%	94.09%	95.68%	95.33%	95.71%
12-19 years	83.91%	91.30%	93.60%	93.04%	93.08%
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
20-44 Years	62.89%	72.17%	80.77%	78.19%	70.47%
45-64 Years	71.91%	81.51%	87.72%	86.64%	85.68%
65+ Years	78.39%	85.39%	87.91%	95.30%	94.22%
Total	66.65%	76.08%	83.67%	82.63%	79.94%
Medication Management for People With Asthma (MMA)					
5-11 Years - 50% Compliance	N/A	56.54%	56.66%	53.09%	43.94%
12-18 Years - 50% Compliance	N/A	56.48%	53.98%	51.44%	46.30%
19-50 Years - 50% Compliance	60.78%	68.65%	66.01%	64.53%	64.12%
51-64 Years - 50% Compliance	N/A	76.23%	75.38%	78.33%	79.03%
Total - 50% Compliance	63.46%	63.93%	62.22%	60.27%	62.93%
5-11 Years - 75% Compliance	N/A	28.74%	33.99%	29.71%	27.27%
12-18 Years - 75% Compliance	N/A	32.89%	31.51%	29.69%	25.93%
19-50 Years - 75% Compliance	41.18%	42.16%	45.42%	43.43%	51.91%
51-64 Years - 75% Compliance	N/A	54.72%	55.33%	58.57%	58.06%
Total - 75% Compliance	41.35%	38.56%	40.71%	38.55%	45.87%
Asthma Medication Ratio (AMR)					
5-11 Years	N/A	70.65%	71.27%	71.16%	68.67%
12-18 Years	N/A	62.47%	59.75%	59.13%	70.49%
19-50 Years	45.07%	48.11%	51.76%	50.40%	55.62%
51-64 Years	42.86%	46.31%	52.82%	52.89%	58.71%
Total	46.43%	56.32%	58.71%	58.40%	60.90%
Annual Dental Visit (ADV)					

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
2-3 Years	37.52%	45.36%	51.06%	50.18%	52.83%
4-6 Years	52.65%	61.96%	70.64%	72.54%	62.11%
7-10 Years	56.14%	66.64%	74.21%	75.34%	69.61%
11-14 Years	52.85%	62.51%	71.81%	72.32%	65.68%
15-18 Years	47.52%	55.71%	64.00%	62.21%	57.95%
19-20 Years	32.47%	39.46%	49.48%	48.05%	37.67%
Total	48.86%	58.69%	67.26%	67.44%	61.30%
Use of Opioids at High Dosage (UOD)[2,9]					
Eligible Population	14.77%	11.93%	9.17%	8.92%	8.32%
Use of Opioids From Multiple Providers (UOP)[2,9]					
Multiple Prescribers	15.51%	19.53%	24.20%	12.76%	13.43%
Multiple Pharmacies	7.59%	2.08%	5.36%	2.62%	2.63%
Multiple Prescribers and Multiple Pharmacies	1.98%	1.36%	3.01%	1.14%	1.32%
Risk of Continued Opioid Use (COU)[2,5,8]					
18-64 Years - >=15 Days Covered	NR	2.06%	12.83%	10.29%	17.93%
18-64 Years - >=31 Days Covered	NR	1.44%	5.14%	3.88%	6.40%
65+ Years - >=15 Days Covered	NR	6.32%	34.57%	34.44%	36.55%
65+ Years - >=31 Days Covered	NR	4.21%	10.90%	10.40%	13.71%
Total - >=15 Days Covered	NR	2.12%	13.08%	11.88%	19.74%
Total - >=31 Days Covered	NR	1.48%	5.21%	4.31%	7.11%
Plan All-Cause Readmissions (PCR)[6,8]					
1-3 Index Stays per Year - 18-44 Years	NR	7.57%	7.91%	6.82%	10.90%
1-3 Index Stays per Year - 45-54 Years	NR	8.35%	8.64%	8.40%	7.02%
1-3 Index Stays per Year - 55-64 Years	NR	9.08%	10.63%	9.62%	9.62%
1-3 Index Stays per Year - Total	NR	8.27%	8.94%	8.22%	9.37%
Observed-to-Expected Ratio	NR	0.48	0.55	0.50	0.57
4+ Index Stays per Year - 18-44 Years	NR	47.39%	48.46%	45.60%	63.53%
4+ Index Stays per Year - 45-54 Years	NR	44.12%	43.27%	49.74%	60.22%
4+ Index Stays per Year - 55-64 Years	NR	42.74%	48.09%	40.43%	44.83%
4+ Index Stays per Year - Total	NR	44.99%	46.87%	44.89%	58.00%
Observed-to-Expected Ratio	NR	1.16	1.26	1.23	1.26
Total Index Stays per Year - 18-44 Years	NR	14.88%	15.73%	13.27%	24.92%
Total Index Stays per Year - 45-54 Years	NR	14.70%	15.93%	15.10%	18.04%
Total Index Stays per Year - 55-64 Years	NR	15.32%	18.44%	14.64%	14.85%
Total Index Stays per Year - Total	NR	14.97%	16.61%	14.24%	19.55%
Observed-to-Expected Ratio	NR	0.71	0.81	0.72	0.86
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2]					
1 - 5 Years	N/A	N/A	0.00%	N/A	N/A
6 - 11 Years	N/A	0.00%	1.77%	0.79%	N/A
12 - 17 Years	N/A	6.07%	4.71%	4.62%	4.00%
Total	N/A	3.94%	3.47%	3.33%	2.70%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)[5]					
1-5 Years	N/A	N/A	11.22%	N/A	N/A
6-11 Years	N/A	32.24%	24.57%	32.39%	32.26%
12-17 Years	N/A	43.70%	32.19%	44.73%	46.03%
Total	32.26%	39.31%	28.70%	40.40%	41.67%

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)[7]					
Total - <1 Years	619.22	775.44	833.61	848.27	726.78
Total - 1-9 Years	296.69	350.98	379.51	399.71	378.20
Total - 10-19 Years	188.30	258.11	291.77	277.07	278.44
Total - 20-44 Years	220.68	290.58	392.92	366.27	329.70
Total - 45-64 Years	372.27	534.67	668.90	613.83	694.30
Total - 65-74 Years	494.92	716.39	754.44	921.18	1,044.66
Total - 75-84 Years	508.36	602.92	744.94	936.35	1,063.82
Total - 85+ Years	385.38	562.27	716.20	841.55	1,115.16
Total - Unknown Years	N/A	N/A	N/A	N/A	N/A
Total - Total Years	281.01	358.61	424.04	425.80	475.75
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	1,166.67	N/A
Dual Eligibles - 10-19 Years	0.00	N/A	N/A	200.00	N/A
Dual Eligibles - 20-44 Years	192.86	19.23	860.53	540.76	674.85
Dual Eligibles - 45-64 Years	569.77	220.43	1,062.57	960.97	1,170.37
Dual Eligibles - 65-74 Years	405.77	136.36	1,191.06	982.38	1,211.99
Dual Eligibles - 75-84 Years	638.69	125.00	1,509.52	1,025.66	1,262.80
Dual Eligibles - 85+ Years	273.38	N/A	1,256.51	959.96	1,340.28
Dual Eligibles - Unknown Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - Total Years	446.06	167.79	1,208.22	942.35	1,202.86
Disabled - <1 Years	987.34	740.83	1,386.47	1,050.89	1,200.00
Disabled - 1-9 Years	306.21	437.68	531.23	499.91	476.27
Disabled - 10-19 Years	180.14	264.37	349.39	316.46	358.55
Disabled - 20-44 Years	325.30	317.49	515.54	359.99	680.52
Disabled - 45-64 Years	694.85	798.15	975.80	867.38	1,215.10
Disabled - 65-74 Years	523.05	721.30	748.71	674.54	1,019.86
Disabled - 75-84 Years	481.52	604.03	724.49	662.68	984.24
Disabled - 85+ Years	430.16	562.27	662.50	594.95	1,052.06
Disabled - Unknown Years	N/A	N/A	N/A	N/A	N/A
Disabled - Total Years	478.74	530.90	694.42	568.56	966.55
Other Low Income - <1 Years	617.71	775.69	830.43	846.62	723.62
Other Low Income - 1-9 Years	296.47	348.76	375.14	396.85	376.23
Other Low Income - 10-19 Years	188.59	257.79	288.88	275.06	275.55
Other Low Income - 20-44 Years	217.93	288.25	384.54	363.89	306.34
Other Low Income - 45-64 Years	343.17	482.45	602.79	538.31	570.14
Other Low Income - 65-74 Years	460.00	626.79	612.73	532.54	90.13
Other Low Income - 75-84 Years	N/A	N/A	N/A	142.86	2.49
Other Low Income - 85+ Years	0.00	N/A	309.24	0.00	0.00
Other Low Income - Unknown Years	N/A	N/A	N/A	N/A	N/A
Other Low Income - Total Years	269.72	343.52	402.03	390.12	385.28
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)[7]					
Total - <1 Years	96.45	89.90	110.33	73.25	106.79
Total - 1-9 Years	51.35	47.14	56.03	40.39	52.67
Total - 10-19 Years	34.20	31.74	40.93	32.01	35.77
Total - 20-44 Years	70.15	68.01	90.94	64.17	75.84

HEDIS 2019 Performance Measure	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Total - 45-64 Years	54.51	61.02	72.73	60.87	66.63
Total - 65-74 Years	25.99	40.21	34.48	55.17	52.34
Total - 75-84 Years	21.10	24.90	32.58	49.49	49.86
Total - 85+ Years	21.59	25.63	35.95	53.29	51.81
Total - Unknown Years	N/A	N/A	N/A	N/A	N/A
Total - Total Years	58.23	53.45	65.95	49.42	61.36
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	166.67	N/A
Dual Eligibles - 10-19 Years	0.00	N/A	N/A	0.00	N/A
Dual Eligibles - 20-44 Years	107.14	19.23	65.28	117.50	183.37
Dual Eligibles - 45-64 Years	50.39	21.51	84.59	110.48	121.86
Dual Eligibles - 65-74 Years	24.86	22.73	47.77	62.00	72.52
Dual Eligibles - 75-84 Years	25.64	0.00	67.35	56.45	67.67
Dual Eligibles - 85+ Years	0.00	N/A	48.10	62.78	65.59
Dual Eligibles - Unknown Years	N/A	N/A	N/A	N/A	N/A
Dual Eligibles - Total Years	37.49	20.13	62.32	79.00	85.81
Disabled - <1 Years	177.22	64.22	161.49	132.47	109.09
Disabled - 1-9 Years	48.32	66.73	81.43	73.01	79.96
Disabled - 10-19 Years	44.83	44.58	64.65	52.28	67.21
Disabled - 20-44 Years	168.93	84.04	139.98	90.69	158.72
Disabled - 45-64 Years	112.78	108.05	131.01	112.01	131.88
Disabled - 65-74 Years	26.66	40.34	34.26	26.92	33.44
Disabled - 75-84 Years	20.16	24.96	31.65	28.16	32.30
Disabled - 85+ Years	28.82	25.63	34.83	33.49	42.66
Disabled - Unknown Years	N/A	N/A	N/A	N/A	N/A
Disabled - Total Years	87.82	79.49	107.54	81.88	104.36
Other Low Income - <1 Years	96.12	90.08	110.03	72.77	106.77
Other Low Income - 1-9 Years	51.42	46.64	55.30	39.46	52.12
Other Low Income - 10-19 Years	33.84	31.08	39.74	30.98	34.64
Other Low Income - 20-44 Years	67.45	66.62	87.62	61.31	70.10
Other Low Income - 45-64 Years	49.49	51.69	60.22	47.48	51.29
Other Low Income - 65-74 Years	0.00	38.28	37.14	43.39	2.13
Other Low Income - 75-84 Years	N/A	N/A	N/A	0.00	0.00
Other Low Income - 85+ Years	0.00	N/A	24.10	0.00	0.00
Other Low Income - Unknown Years	N/A	N/A	N/A	N/A	N/A
Other Low Income - Total Years	56.81	51.17	62.61	45.53	55.65

[1] W34 was calculated administratively by ABHNJ in MY 2018, the other four plans reported via hybrid.

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

[3] Follow-up After Hospitalization and Follow-up After Emergency Department Visit for Mental Illness are only applicable for those members that receive a behavioral health benefit from the MCO (MLTSS, DDD, and FIDE SNP).

[4] FUM and FUH have new age band breakouts for those measures for MY 2018.

[5] COU and APM are new measures this year.

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

[7] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance.

[8] In MY 2018, Aetna did not report for COU and PCR measure.

[9] For the current grid, rates for the UOP and UOD measures were changed from being reported as millages to percentages.

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.

2019 New Jersey State-Specific Measures and Core Set Measures

2019 New Jersey State-Specific Measures

As more patients with disabilities and chronic conditions transition to managed care from 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.

2019 New Jersey Core Set Measures

In addition to the CHIPRA Core Set measure Developmental Screening (DEV-CH), one Adult Core Set measure for Diabetes Short-Term Complications Admission Rate (PQI01-AD) was added to MY 2018 and is defined by two age groups 18-64 years, and 65 years and older. Admissions per 100,000 Member Months are reported for this measure.
All MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) reported the required measures for MY 2018. ABHNJ, AGNJ and UHCCP did not follow the requirement of including dual eligible members in the Preventive Dental Visit measure. These plans received a designation of NR for these measures for MY 2018.

1. For MY 2018, the FIDE SNP dual members were excluded for all measures except for Preventive Dental visit.
2. Three MCOs did not accurately report members in the dual eligible population for the Preventive Dental Visit measure properly and the three MCOs received an NR for MY 2018.
    a. ABHNJ's MY 2018 submission showed denominator decreases due to an error attributed to how ABHNJ is identifying their dual eligible population.
    b. AGNJ indicated that they have historically excluded the dual eligible population from their reporting of the measure.
    c. UHCCP identified a discrepancy with the identification and reporting of the dual eligible population for MY 2018.

Table 8: 2019 New Jersey State-Specific Performance Measures/Core Set Measures

2019 NJ-Specific Performance Measure / Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Total Medicaid - 20-44 Years	62.89%	72.17%	80.77%	78.19%	70.47%
Total Medicaid - 45-64 Years	71.91%	81.51%	87.72%	86.64%	85.68%
Total Medicaid - 65+ Years	78.39%	85.39%	87.91%	95.30%	94.22%
Total Medicaid - Total	66.65%	76.08%	83.67%	82.63%	79.94%
Dual Eligibles - 20-44 Years	N/A	82.35%	N/A	93.48%	91.46%
Dual Eligibles - 45-64 Years	N/A	91.56%	100.00%	97.71%	97.74%
Dual Eligibles - 65+ Years	80.00%	94.20%	98.00%	97.67%	97.79%
Dual Eligibles - Total	79.76%	90.16%	98.55%	97.29%	97.45%
Disabled - 20-44 Years	75.96%	69.46%	85.28%	77.06%	84.06%
Disabled - 45-64 Years	86.77%	87.02%	92.85%	91.95%	92.53%
Disabled - 65+ Years	78.19%	85.35%	87.72%	87.65%	90.54%
Disabled - Total	81.14%	79.84%	89.75%	85.41%	89.95%
Other Low Income - 20-44 Years	62.31%	72.46%	80.33%	78.03%	68.71%
Other Low Income - 45-64 Years	70.14%	79.69%	86.29%	84.47%	83.31%

2019 NJ-Specific Performance Measure / Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Other Low Income - 65+ Years	N/A	N/A	71.43%	73.33%	N/A
Other Low Income - Total	65.10%	75.08%	82.52%	80.31%	75.45%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Total Medicaid - 12-24 Months	93.21%	96.86%	96.40%	97.24%	95.27%
Total Medicaid - 25 Months - 6 Years	88.65%	91.72%	93.00%	93.58%	91.79%
Total Medicaid - 7-11 Years	87.44%	94.09%	95.68%	95.33%	95.71%
Total Medicaid - 12-19 Years	83.91%	91.30%	93.60%	93.04%	93.08%
Total Medicaid - 12 Months -19 Years	88.13%	92.50%	94.15%	94.10%	93.48%
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
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	88.46%	94.66%	93.21%	N/A
Disabled - 25 Months - 6 Years	83.61%	90.99%	93.96%	92.31%	91.78%
Disabled - 7-11 Years	N/A	93.24%	96.32%	95.09%	94.26%
Disabled - 12-19 Years	80.49%	86.61%	93.26%	91.21%	95.33%
Disabled - Total - 12 Months -19 Years	83.21%	89.38%	94.35%	92.60%	94.00%
Other Low Income - 12-24 Months	93.28%	96.98%	96.42%	97.30%	95.47%
Other Low Income - 25 Months - 6 Years	88.80%	91.74%	92.97%	93.62%	91.79%
Other Low Income - 7-11 Years	87.50%	94.13%	95.65%	95.34%	95.78%
Other Low Income - 12-19 Years	84.05%	91.59%	93.62%	93.15%	92.94%
Other Low Income - Total - 12 Months-19 Years	88.27%	92.64%	94.14%	94.17%	93.46%
Preventive Dental Visit					
Total - 2-3 Years	NR	NR	50.17%	NR	44.98%
Total - 4-6 Years	NR	NR	68.28%	NR	53.95%
Total - 7-10 Years	NR	NR	71.13%	NR	61.39%
Total - 11-14 Years	NR	NR	67.34%	NR	57.79%
Total - 15-18 Years	NR	NR	57.34%	NR	48.50%
Total - 19-21 Years	NR	NR	42.02%	NR	25.22%
Total - 22-34 Years	NR	NR	36.64%	NR	24.65%
Total - 35-64 Years	NR	NR	36.39%	NR	29.55%
Total - 65+ Years	NR	NR	28.84%	NR	27.57%
Total - Total	NR	NR	49.64%	NR	35.09%
Dual Eligibles - 2-3 Years	NR	NR	N/A	NR	N/A
Dual Eligibles - 4-6 Years	NR	NR	N/A	NR	N/A
Dual Eligibles - 7-10 Years	NR	NR	N/A	NR	N/A
Dual Eligibles - 11-14 Years	NR	NR	N/A	NR	N/A
Dual Eligibles - 15-18 Years	NR	NR	N/A	NR	N/A
Dual Eligibles - 19-21 Years	NR	NR	42.05%	NR	N/A
Dual Eligibles - 22-34 Years	NR	NR	36.82%	NR	28.19%
Dual Eligibles - 35-64 Years	NR	NR	39.77%	NR	31.17%
Dual Eligibles - 65+ Years	NR	NR	29.44%	NR	28.12%
Dual Eligibles - Total	NR	NR	33.42%	NR	28.64%

2019 NJ-Specific Performance Measure / Core Set Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP
Disabled - 2-3 Years	NR	NR	41.87%	NR	N/A
Disabled - 4-6 Years	NR	NR	57.09%	NR	39.74%
Disabled - 7-10 Years	NR	NR	61.14%	NR	43.95%
Disabled - 11-14 Years	NR	NR	56.85%	NR	41.51%
Disabled - 15-18 Years	NR	NR	49.61%	NR	35.87%
Disabled - 19-21 Years	NR	NR	34.70%	NR	29.20%
Disabled - 22-34 Years	NR	NR	33.64%	NR	35.53%
Disabled - 35-64 Years	NR	NR	30.23%	NR	30.93%
Disabled - 65+ Years	NR	NR	23.35%	NR	22.80%
Disabled - Total	NR	NR	36.85%	NR	30.21%
Other Low Income - 2-3 Years	NR	NR	50.32%	NR	45.07%
Other Low Income - 4-6 Years	NR	NR	68.69%	NR	54.31%
Other Low Income - 7-10 Years	NR	NR	71.65%	NR	62.08%
Other Low Income - 11-14 Years	NR	NR	67.92%	NR	58.47%
Other Low Income - 15-18 Years	NR	NR	57.83%	NR	49.17%
Other Low Income - 19-21 Years	NR	NR	42.83%	NR	25.08%
Other Low Income - 22-34 Years	NR	NR	36.97%	NR	23.66%
Other Low Income - 35-64 Years	NR	NR	37.03%	NR	28.99%
Other Low Income - 65+ Years	NR	NR	33.47%	NR	N/A
Other Low Income - Total	NR	NR	53.10%	NR	38.20%
Developmental Screening					
1 Year Old	26.26%	34.47%	33.71%	21.24%	33.67%
2 Year Old	37.34%	51.07%	42.38%	37.92%	34.63%
3 Year Old	29.18%	45.11%	38.26%	35.33%	33.14%
Total - 1-3 Years	30.95%	44.11%	38.39%	32.20%	33.81%
Diabetes Short-Term Complications Admission (PQI01) - Admissions per 100,000 Member Months					
18-64 Years	13.11	12.68	15.21	11.49	21.85
65 Years and Older	0.00	10.69	5.63	6.26	7.72
Total	12.74	12.64	15.06	11.12	17.79

Designation N/A: Indicates that MCO had a denominator of less than 30.
Designation NR: Indicates the rate is not reported based on MCO submissions.

2019 MLTSS Performance Measure Validation

During July 1, 2017–June 30, 2018, 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 2018–June 2019 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 #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 HEDIS IPU for MLTSS HCBS members, and PM #27 HEDIS IPU for MLTSS NF members. Reported quarterly and annually.

PM #28 and PM #29: All-Cause Readmissions of MLTSS Members to Hospital Within 30 Days
Assesses the number of acute inpatient stays during the measurement period for MLTSS members that were followed by an unplanned acute inpatient readmission within 30 days of the index discharge date. Two rates are reported: PM#28 HEDIS PCR for MLTSS HCBS members, and PM #29 HEDIS PCR for MLTSS NF members. Reported quarterly and annually.

PMs #30 and #31: Emergency Department Utilization by MLTSS Members
Summarizes utilization of Emergency Department (ED) visits for MLTSS members. Two rates are reported: PM #30 HEDIS AMB for MLTSS HCBS members, and PM #31 HEDIS AMB for MLTSS NF members. Reported quarterly and annually.

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

PM #36 and PM #38: Follow-up After Mental Health Hospitalization for MLTSS Members
Assesses the percentage of discharges for eligible MLTSS members who were hospitalized for treatment of selected mental health disorders and who had a follow-up visit with a mental health practitioner within 30 days of discharge. Two

rates are reported: PM#36 HEDIS FUH for MLTSS HCBS members, and PM #38 HEDIS FUH for MLTSS NF members. Reported quarterly and annually.

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

PMs #44 and PM #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS Members
Assesses the percentage of ED visits for MLTSS members with a principal diagnosis of Mental Illness and who had a follow-up visit for Mental Illness within 30 days of the ED visit. Two rates are reported: PM #44 HEDIS FUM for MLTSS HCBS members, and PM #45 HEDIS FUM for MLTSS NF members. Reported quarterly and annually.

PMs #46: MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services
Assesses the number of unique MLTSS HCBS members not receiving MLTSS HCBS, PCA or Medical Day Services. Two rates are produced. The second, PM 46a requires continuous enrollment. Reported quarterly and annually.

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 2019 reports ran through February 2020, 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 2018–June 2019 measurement period were developed for the following PMs: #4: Timeliness of NF Level of Care Assessment by MCO; #18: Critical Incident Reporting, #20:MLTSS Members Receiving MLTSS Services; #21: MLTSS Members Transitioned from NF to Community, #23: NF to 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; PM #28 and PM #29: All-Cause Readmissions of MLTSS Members to Hospital Within 30 Days; #30 and #31: Emergency Department 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 MLTSS 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; #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members; and #46: Follow-up MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services.

IPRO worked with DMAHS to develop the specifications for the following measures in the 4th quarter of 2019 for the July 2019–June 2020 measurement period:

- #20a: New MLTSS Members with MLTSS Services Within 120 Days of Enrollment;

- #47: Post Hospitalization Institutional Care for MLTSS HCBS Members;

Also, following the release of NCQA's *Rules for Allowable Adjustments of HEDIS 2020*, in the 4th quarter of 2019, IPRO worked with DMAHS to ensure that HEDIS-based measures followed the NCQA guidance. For the upcoming year, 2020 specifications directed the MCOs to produce the following measures following HEDIS methodology and reporting the unmodified HEDIS measure for the MLTSS subpopulations of interest:
#48, #49: HEDIS Hospitalization for Potentially Preventable Complications (HPC);
#50, #51: HEDIS Follow-up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC); and
#52, #53: HEDIS Care for Older Adults (COA).

Results of 2019 Quarterly Monitored MLTSS Rates

The following are the rates reported by the MCOs in 2019 and monitored by IPRO to ensure no issues with the reported numbers. Rates reported that are considered with issues, such as significant changes in denominator or numerator, are not included in the following results and IPRO will follow up with the MCOs to resolve the issues.

- PM #4 Timeliness of NF Level of Care Assessment by MCO: the monthly rates range from 90% to 100%, except few exceptions with denominator less than 30. The statewide rates steadily stays around 94%.
- PM #20 MLTSS Members Receiving MLTSS Services: the quarterly rates very from 62% to 86%. Rates for all MCOs except WellCare remain around 80%, while WellCare rates hover around 63%. The statewide rates steadily stays around 75%.
- PM #21 MLTSS Members Transitioned from NF to Community: the quarterly rates remain low, from 0.3% to 2.0%, and the statewide rates vary from 0.6% to 2.4%.
- PM #23 MLTSS NF to HCBS Transitions who Returned to NF within 90 Days: the MCO rates vary from 0% to 25%. However, most of the reported quarterly denominators are constantly less than 30. The statewide rates range from 6% to 11%.
- PM #24 MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days: only Horizon and United have denominators above 30, and their quarterly rates range from 88% to 95%. The statewide rates are within 87% to 93%.
- PM #25 MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less: Same as PM #24 that only Horizon and United have denominators above 30. Their quarterly rates range from 5% to 12%. The statewide rates are within 9% to 14%.
- PM ##26 and #27 Acute Inpatient Utilization by MLTSS Members: Rates are not reported for these two measures, as two MCOs have outstanding issues with reported rates (Amerigroup and WellCare), and one MCO (United) only reported rate for one quarter.

Rates for the following PMs are not reported due to high portion of rates that haven't been submitted by the MCOs:

- PM #28 and PM #29 All-Cause Readmissions of MLTSS Members to Hospital Within 30 Days
- PMs #30 and #31 Emergency Department Utilization by MLTSS Members
- PMs #33, #34 and #41 MLTSS Services Used by MLTSS HCBS Members
- PM #36 and PM #38 Follow-up After Mental Health Hospitalization for MLTSS Members
- PMs #39 and #40 MLTSS Members with Select Behavioral Health Diagnoses
- PMs #42 and PM #43 Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS Members
- PMs #44 and PM #45 Follow-up After Emergency Department Visit for Mental Illness for MLTSS Members

PM #46, MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services rates are not listed. In January 2020 reporting discrepancies were identified that indicated reconsideration of specifications were required. PM#46 specifications are under revision and MCOs are required to report amended rates following the release of final revised specifications.

2019 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the POC. This measure ensures MLTSS HCBS are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. 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, 2018–June 30, 2019, 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 (black-out periods).

A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and black-out period information for these cases. Members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2018 and June 30, 2019.

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.

There are six services removed from prior year: Cognitive Therapy, Occupational Therapy, Physical Therapy, Social Adult Day Care, TBI Behavioral Management, and Speech, Language and Hearing Therapy. Upon review of MCO claims data and during the conduct of primary source verification to ensure the quality of claims data, these services were found highly subject to member preference on a daily basis and could not be delivered on a routine basis. IPRO and DMAHS discussed cases with these services and decided to remove them from the scope of PM #13.

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

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

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. The review is underway and the EQRO is working closely with the MCOs to complete the validation in early 2020.

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 2019-December 2019, this QTR includes IPRO's evaluation of the April 2019 and August 2019 PIP report submissions and Fall 2019 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 2019, AGNJ submitted their April 2019 update and August 2019 progress report for the "Preterm Birth Rates" PIP. All other MCOs submitted their Final reports for the "Preterm Birth Rates" PIP in 2018. All MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) submitted updates and progress reports for their PIPs relating to "Improving Developmental Screening and Referral Rates to Early Intervention for Children 0-3 years". ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted the baseline reports and the project year 1 progress reports for the PIP titled, "MCO Adolescent Risk Behaviors and Depression Collaborative".

The MCO's were not required to submit an April update for any of the MLTSS PIPs in 2019. ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted final progress reports for the Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population. AGNJ submitted the baseline reports and project year 1 progress reports for their new MLTSS Falls PIP. ABHNJ, AGNJ, HNJH, UHCCP and WCHP submitted baseline reports and project year 1 progress reports for "MLTSS Gaps in Care."

The MCOs participated in a collaborative PIP initiated in the fall of 2018 titled, "MCO Adolescent Risk Behaviors and Depression Collaborative." IPRO's role was to arrange and facilitate an introductory meeting with the MCOs to orient them to the topic, 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 attended subsequent meetings. These meetings were regularly scheduled and chaired by the MCOs. IPRO provided guidance and final approval for the collaborative aim and standardized metrics. IPRO will continue to validate the data abstraction tool as needed as this is an evolving tool and may be subject to change in the future. IPRO will produce 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. The MCOs continue to hold monthly collaborative calls with IPRO and the State.

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

Assessment Methodology

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

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

Review Element 4:	Barrier Analysis
Review Element 5:	Robust Interventions
Review Element 6:	Results Table
Review Element 7:	Discussion and Validity of Reported Improvement
Review Element 8:	Sustainability
Review Element 9:	Healthcare Disparities (unscored)

IPRO reviewed the reports and provided suggestions to the MCOs to enhance their studies. Note: Due to the timing of the proposal resubmissions, MCOs did not have to submit the first update in April 2019 for the MLTSS Gaps in Care PIPs. Each of the five MCOs submitted the following PIPs:

ABHNJ

PIP 1: Reduction in Falls Among Home and Community Based Members in MLTSS (Final Report)
PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Reduction in ER and IP Utilization Through Enhanced Chronic Disease Management
In 2019, the MCO submitted progress reports for PIP 1, PIP 2, PIP 3, and a resubmission of the proposal and a MY 1 progress report for PIP 4.

AGNJ

PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population (Final Report) Note: The acceptance of the closed out PIP to be replaced by the New Falls PIP
PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old
PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%, (previously entitled Reduction of Preterm Births – Increasing Progesterone Utilization Rates prior to the change in aim statement and goals in the June 2017 project update)
PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 5: Decreasing Gaps In Care In Managed Long Term Services and Supports (MLTSS)
In 2019, the MCO submitted progress reports for PIP 1, PIP 2, PIP 3, PIP 4 and a resubmission of the proposal and a MY 1 progress report for PIP 5.

HNJH

PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Supports (MLTSS) Members (Final Report)
PIP 2: Developmental Screening and Early Intervention in Young Children
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Reducing Admissions, Readmissions and Gaps in Services For Members With Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population
In 2019, the MCO submitted progress reports for PIP 1, PIP 2, PIP 3, a resubmission of the proposal and a MY 1 progress report for PIP 4.

UHCCP

PIP 1: Prevention of Recurrent Falls in MLTSS Members with History of Falls (Final Report)
PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population
In 2019, the MCO submitted progress reports for PIP 1, PIP 2, PIP 3 and a resubmission of the proposal and a MY 1 progress report for PIP 4.

WCHP

PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall (Final Report)
PIP 2: Increasing the Rate of developmental Screening and Early Intervention in Children 0-3 Years of Age
PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative
PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis
In 2019, the MCO submitted progress reports for PIP 1, PIP 2, PIP 3 and a resubmission of the proposal and a MY 1 progress report for PIP 4.

In June 2019, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed the two PIP templates to ensure the MCOs were utilizing the correct versions. The training focused on the development of strong interventions, evaluation of interventions in current PIPs, PIP exercises focused on interventions, and a review of the overall PIP process. The MCOs will continue to submit project updates in April and August progress reports each year.

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

Summary of PIP Performance

PIP Strengths

The "Preventing Recurrent Falls in MLTSS Members with History of Falls" PIP was concluded in August 2019 for four MCOs (ABHNJ, HNJH, UHCCP, and WCHP). The interventions and intervention tracking measures (ITMs) utilized by the four MCO's showed evidence of a positive impact in a decrease of falls in their membership. The MCOs will continue to use these interventions as well as, identifying any additional interventions that will assist this population.

All five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) have identified a population relevant to each MCO's project and contained strong rationale for their study for the Gaps in Care PIP. Interventions were identified based on continued barrier analysis. All MCOs identified a gap in care and submitted progress reports. The MCOs will continue to identify any barriers for this PIP as well as, examining interventions to ensure they are making an impact on their selected population of focus.

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. This remains an area for improvement and was discussed at the June 2019 PIP training. All MCOs will need to review barriers and interventions and ensure interventions and ITMs are measuring for outcomes through medical record review and education with providers and members.

Overall, continued improvement is needed regarding the relationship between barriers, interventions, ITMs 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 2019, IPRO continues to monitor encounter data submissions and patterns.

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from DXC Technology. IPRO loads the following data to IPRO's Statistical Analysis Software (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. During 2019 IPRO worked closely with DXC Technology to address any changes to the eligibility and encounter data extracts.

Focused Quality Studies

Non-clinical Focused Study Pharmacy Claims vs. Encounter Data

In 2019, the EQRO has initiated a pharmacy audit study with the Core Medicaid and FIDE SNP MCOs and EDMU. The objective of the audit is to verify the accuracy of pharmacy encounter data submitted to DMAHS by all five NJ Medicaid MCOs. The pharmacy encounter data submitted to DMAHS will be reconciled to the corresponding source claim data from the originally adjudicated claims and differences will be identified and investigated. Review period of the audit includes a nine-month survey period of April 1, 2018 to December 31, 2018; the EQRO has selected a random sample of 1,000 Core Medicaid and 1,000 FIDE SNP pharmacy encounters for each month for each NJ Medicaid MCO. The MCOs have provided the adjudicated claim information and the EQRO is in the process of identifying the discrepancies. The review is underway and the EQRO is working closely with the MCOs and EDMU to complete the Pharmacy audit study in 2020.

2019 Maternal Mortality Focused Study

In 2019, at the request of DMAHS, IPRO began developing a clinical focused study on maternal mortality. This study aims to investigate pregnancy-associated deaths in the New Jersey Medicaid population and explore the predictors of maternal mortality. For the purposes of this study, pregnancy-associated death will be defined as death of a woman within 1 year of the termination of a pregnancy (excluding those terminated by elective abortion).This will be a retrospective cohort study of Medicaid-enrolled women who died in 2017 and 2018 within one year of the termination of a pregnancy that occurred while the woman was enrolled in New Jersey Medicaid. Because of the anticipated small population of focus, statistical comparisons to the general maternal population will not be conducted. The focused study is currently ongoing, and findings are anticipated to be presented to DMAHS in 2020.

Study questions will include:

1. What is the total number of pregnancy-associated deaths in the New Jersey Medicaid population during the study period?
2. Of these pregnancy-associated deaths, how many were pregnancy-related?
3. Are there disparities in pregnancy-associated deaths in the New Jersey Medicaid population associated with member demographics or health-related variables such as:
    a. race/ethnicity;
    b. age at death;
    c. medical and behavioral risk factors such as hypertension (pre-pregnancy and gestational), diabetes (pre-pregnancy and gestational), obesity, and smoking;
    d. when prenatal care was initiated (i.e., 1st trimester, 2nd trimester, 3rd trimester, or no prenatal care) and the frequency of prenatal visits; and
    e. postpartum care on or between the 21st day and the 56th day after delivery of a live birth.

Data collection will include medical records, MCO member records, administrative data, hospital records (when available and FFS claims).

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

2019 CAHPS Survey

Results from the HEDIS-CAHPS 5.0H Survey for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following three survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare: Center for the Study of Services (CSS), DSS Research, and SPH Analytics. IPRO

subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2018 through December 31, 2018, 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 2019 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 1,926 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 22.4%. Composite results of the adult NJ FamilyCare overall weighted positive responses for the five MCOs were: 93.3% for how well doctors communicate; 86.6% for customer service; 81.5% for getting needed care; 78.0% for shared decision making; and 77.3% for getting care quickly.

For the child survey, a total random sample of 12,062 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 2,772 ABHNJ enrollees, 2,145 AGNJ enrollees, 1,650 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 2,417 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 20.9%. Composite results of the Child NJ FamilyCare overall weighted positive responses for the five MCOs were: 91.5% for how well doctors communicate; 86.3% for customer service; 82.2% for getting care quickly; 81.4% for getting needed care; and 74.6% 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 562 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 26.5%. Composite results of the CHIP NJ FamilyCare overall statewide positive responses were: 94.4% for how well doctors communicate; 87.3% for customer service; 85.8% for getting care quickly; 85.6% for getting needed care; and 78.9% for shared decision making.

Care Management Audits

2019 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 2018 audit with comparisons to MY 2017 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 2019 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 10 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 MY 2018 rates across all MCOs, populations, and categories ranged from 51% to 100%. Scores for the Identification category ranged from 58% to 100% across all MCOs for all populations (GP, DDD, DCP&P). Scores for Outreach ranged from 57% to 100% for all MCOs for all populations. Scores for the Preventive Services Category ranged from 51% to 100% across all MCOs for all populations. Scores for Continuity of Care ranged from 64% to 100% across all MCOs for all populations. Scores for Coordination of Services ranged from 81% to 100% across all MCOs for all populations (**Table 10**).

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 10**). Out of the five metrics across all populations and across five plans that were comparable to 2017 (75 in total), eighteen (18) scored higher, eighteen (18) remained the same, and thirty-nine (39) scored lower in 2018.

WCHP and AGNJ scored at or above 90% in 12 out of 15 categories for all populations. UHCCP scored above 90% in 11 out of 15 categories. ABHNJ scored above 90% in 10 of the 15 categories and HNJH scored above 90% in 9 of the 15 categories. (**Table 10**).WCHP showed the greatest improvement in any category, with a 23 percentage point increase in Preventive Services for the General Population. AGNJ had the highest number of categories (7 out of 15) with an increase, most notably a 12 percentage point increase in Preventive Service categories for the General Population and a 10 percentage point increase in Preventive Service for the DDD Population. A 40 percentage point decrease for ABHNJ in Preventive Services for the General Population was the largest decline from 2017 to 2018 (**Table 10**).

Table 10: Care Management Audit Results

	MCO									
	ABHNJ		AGNJ		HNJH		UHCCP		WCHP	
Response by Category	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
General Population	n = 101	n = 100	n = 100	n = 100	n = 100	n = 100	n = 100	n = 100	n = 100	n = 100
Identification	85%	62%	86%	84%	83%	70%	96%	58%	92%	83%
Outreach	83%	74%	88%	80%	72%	57%	85%	57%	97%	87%
Preventive Service	91%	51%	88%	100%	89%	76%	70%	65%	77%	100%
Continuity of Care	100%	69%	96%	90%	98%	88%	90%	64%	91%	89%
Coordination of Services	100%	99%	100%	89%	100%	86%	100%	97%	99%	98%
DDD	n = 27	n = 21	n = 30	n = 20	n = 100	n = 70	n = 53	n = 47	n = 20	n = 16
Identification	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%
Outreach	100%	100%	97%	100%	87%	98%	99%	96%	100%	97%
Preventive Service	87%	76%	87%	97%	94%	96%	87%	100%	92%	100%
Continuity of Care	99%	99%	97%	100%	90%	93%	99%	96%	100%	100%
Coordination of Services	100%	100%	99%	100%	100%	81%	97%	100%	98%	98%
DCP&P	n = 35	n = 37	n = 113	n = 61	n = 104	n = 100	n = 100	n = 100	n = 26	n = 24
Identification	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outreach	97%	95%	100%	98%	100%	100%	100%	96%	97%	100%
Preventive Service	98%	91%	97%	99%	98%	91%	94%	98%	96%	95%
Continuity of Care	100%	91%	99%	99%	100%	100%	99%	91%	99%	100%
Coordination of Services	100%	96%	99%	98%	100%	100%	99%	100%	100%	97%

DDD: members under the Division of Developmental Disabilities; 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 51% to 100% across all populations for the five categories. For the General Population, compliance rates declined for all 5 categories. For the DDD Population, compliance rates for 4 categories remained the same (Identification, Outreach, Continuity of Care, and Coordination of Services), and 1 category declined (Preventive Services). The DCP&P Population showed declines in compliance rates for four categories and one category (Identification) remained the same.

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

- Coordination of Services (GP) (99%)
- Identification (DDD) (100%)
- Outreach (DDD) (100%)
- Continuity of Care (DDD) (99%)
- Coordination of Services (DDD) (100%)
- Identification (DCP&P) (100%)
- Outreach (DCP&P) (95%)
- Preventive Services (DCP&P) (91%)
- Continuity of Care (DCP&P) (91%)
- Coordination of Services (DCP&P) (96%)

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

- Identification (GP) (62%)
- Outreach (GP) (74%)
- Preventive Services (GP) (51%)
- Continuity of Care (GP) (69%)
- Preventive Services (DDD) (76%)

Four categories of opportunity have been identified for ABHNJ's General Population:

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

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

Preventive Services: ABHNJ should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exams for the child population. Confirmation of childhood immunizations should be obtained from a reliable source, such as the PCP and the NJ immunization registry. 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. ABHNJ should ensure dental needs are addressed for the adult population including documentation of the visits.

Continuity of Care: ABHNJ should ensure the member's CNA and POC are completed timely.

One category of opportunity was identified for the DDD Population:

Preventive Services: Preventive services 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 should be obtained from a reliable source, such as the PCP and the NJ immunization registry. 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.

There were no noted rate increases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017).

Rate decreases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Identification (GP) (-23%)
- Outreach (GP) (-9%)
- Preventive Services (GP) (-40%)
- Continuity of Care (GP) (-31%)
- Preventive Services (DDD) (-11%)
- Preventive Services (DCP&P) (-7%)
- Continuity of Care (DCP&P) (-9%)

AGNJ

AGNJ audit results ranged from 80% to 100% across all populations for the five audit categories. For the General Population, compliance rates improved for 1 category (Preventive Services), and declined for 4 categories (Identification, Outreach, Continuity of Care, and Coordination of Services). For the DDD Population, compliance rates in all five categories showed improvement. The DCP&P Population showed improvement in compliance rates in 1 category (Preventive Services), 2 categories remained the same (Identification and Continuity of Care), and 2 categories declined (Outreach and Coordination of Services).

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

- Identification (GP) (84%)
- Outreach (GP) (80%)
- Preventive Services (GP) (100%)
- Continuity of Care (GP) (90%)
- Coordination of Services (GP) (89%)
- Identification (DDD) (100%)
- Outreach (DDD) (100%)
- Preventive Services (DDD) (97%)
- Continuity of Care (DDD) (100%)
- Coordination of Services (DDD) (100%)
- Identification (DCP&P) (100%)
- Outreach (DCP&P) (98%)
- Preventive Services (DCP&P) (99%)
- Continuity of Care (DCP&P) (99%)
- Coordination of Services (DCP&P) (98%)

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

Rate increases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Preventive Services (GP) (12%)
- Preventive Services (DDD) (10%)

Rate decreases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Outreach (GP) (-8%)
- Continuity of Care (GP) (-6%)
- Coordination of Services (GP) (-11%)

HNJH

HNJH audit results ranged from 57% to 100% across all populations for the five audit categories. For the General Population, compliance rates declined for all 5 categories. The DDD Population showed improvement in compliance rates in 3 categories (Outreach, Preventive Services, and Continuity of Care), 1 category remained the same (Identification), and 1 category declined (Coordination of Services). For the DCP&P Population 4 categories remained the same (Identification, Outreach, Continuity of Care, and Coordination of Services), and 1 category declined (Preventive Services).

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

- Continuity of Care (GP) (88%)
- Coordination of Services (GP) (86%)
- Identification (DDD) (100%)
- Outreach (DDD) (98%)
- Preventive Services (DDD) (96%)
- Continuity of Care (DDD) (93%)
- Coordination of Services (DDD) (81%)
- Identification (DCP&P) (100%)
- Outreach (DCP&P) (100%)
- Preventive Services (DCP&P) (91%)
- Continuity of Care (DCP&P) (100%)
- Coordination of Services (DCP&P) (100%)

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

- Identification (GP) (70%)
- Outreach (GP) (57%)
- Preventive Services (GP) (76%)

Three categories for improvement have been identified for the General Population:

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

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

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

Rate increases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Outreach (DDD) (11%)

Rate decreases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Identification (GP) (-13%)
- Outreach (GP) (-15%)
- Preventive Services (GP) (-13%)
- Continuity of Care (GP) (-10%)
- Coordination of Services (GP) (-14%)
- Coordination of Services (DDD) (-19%)
- Preventive Services (DCP&P) (-7%)

UHCCP

UHCCP audit results ranged from 57% to 100% across all populations for the five audit categories. For the General Population, compliance rates declined for all 5 categories. The DDD Population showed improvement in compliance rates in 2 categories (Preventive Services and Coordination of Services), 1 category remained the same (Identification), and 2 categories declined (Outreach and Continuity of Care). The DCP&P Population showed improvement in compliance rates in 2 categories (Preventive Services and Coordination of Services), 1 category remained the same (Identification), and 2 categories declined (Outreach and Continuity of Care).

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

- Coordination of Services (GP) (97%)
- Identification (DDD) (100%)
- Outreach (DDD) (96%)
- Preventive Services (DDD) (100%)
- Continuity of Care (DDD) (96%)
- Coordination of Services (DDD) (100%)
- Identification (DCP&P) (100%)
- Outreach (DCP&P) (96%)
- Preventive Services (DCP&P) (98%)
- Continuity of Care (DCP&P) (91%)
- Coordination of Services (DCP&P) (100%)

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

- Identification (GP) (58%)
- Outreach (GP) (57%)
- Preventive Services (GP) (65%)
- Continuity of Care (GP) (64%)

Four categories of opportunity have been identified for the General Population;

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

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

Preventive Services: UHCCP should continue to focus on age-appropriate immunizations for the adult populations enrolled in care management. UHCCP should ensure confirmation of lead screening from a reliable source, such as the PCP and the NJ immunization registry, and the results of lead testing should be documented. UHCCP should ensure that dental needs are addressed for all children and adult members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental and preventive services and to educate members of the need/benefit of such services.

Continuity of Care: UHCCP should ensure the member's CNA and POC are completed timely.

Rate increases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Preventive Services (DDD) (13%)

Rate decreases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Identification (GP) (-38%)
- Outreach (GP) (-28%)
- Preventive Services (GP) (-5%)
- Continuity of Care (GP) (-26%)
- Continuity of Care (DCP&P) (-8%)

WCHP

WCHP audit results ranged from 83% to 100% across all populations for the five audit categories. For the General Population, compliance rates improved in 1 category (Preventive Services) and declined in 4 categories (Identification, Outreach, Continuity of Care, and Coordination of Services). The DDD Population showed improvement in compliance rates in 1 category (Preventive Services), 3 categories remained the same (Identification, Continuity of Care, and Coordination of Services), and 1 category declined (Outreach). The DCP&P Population showed improvement in compliance rates in 2 categories (Outreach and Continuity of Care), 1 category remained the same (Identification), and 2 categories declined (Preventive Services and Coordination of Services).

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

- Identification (GP) (83%)
- Outreach (GP) (87%)
- Preventive Services (GP) 100%)
- Continuity of Care (GP) (89%)
- Coordination of Services (GP) (98%)
- Identification (DDD) (100%)
- Outreach (DDD) (97%)
- Preventive Services (DDD) (100%)
- Continuity of Care (DDD) (100%)
- Coordination of Services (DDD) (98%)
- Identification (DCP&P) (100%)
- Outreach (DCP&P) (100%)
- Preventive Services (DCP&P) (95%)
- Continuity of Care (DCP&P) (100%)
- Coordination of Services (DCP&P) (97%)

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

Rate increases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Preventive Services (GP) (23%)
- Preventive Services (DDD) (8%)

Rate decreases of 5% or more in this year's review period (January 1, 2018–December 31, 2018) as compared to the prior review period (January 1, 2017–December 31, 2017) were as follows:

- Identification (GP) (-9%)
- Outreach (GP) (-10%)

2019 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 7/1/2018 through 6/30/2019. The results from the previous review period (7/1/2017–6/30/2018) were compared to the 2019 audit, which includes the new results from 7/1/2018–6/30/2019.

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 NJ FamilyCare Managed Care Contracts (Article 9) dated July 2018 and January 2019. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs,

and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/18 and 1/1/19 (Group C) and existing MMC members enrolled in MLTSS between 7/1/18 and 1/1/19 (Group D), the 2019 audit included a subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/18) and continuously enrolled with the MCO in MLTSS through 6/30/19. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25 members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. 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 11 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 (7/1/2017 to 6/30/2018) to the current review period (7/1/2018 to 6/30/2019) 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 7/1/2018 to 6/30/2019 audit results for Groups C, D and E ranged from 52.9% for PM #11 Plans of Care developed using "person-centered principles", to 97.8% for PM #10 Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment (**Table 11**).

Table 11: MLTSS HCBS Care Management Audit Performance Measure Results for 7/1/2018 to 6/30/2019

Performance Measure		ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[1]		
	Group[2]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]
#8. Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS[4]	C	36.4%	53.2%	16.8	18.8%	91.2%	72.4	76.0%	72.0%	-4.0	50.0%	25.0%	-25.0	50.0%	87.5%	37.5	42.3%	58.6%	16.3
	D	27.8%	55.0%	27.2	23.6%	92.3%	68.7	84.6%	91.8%	7.2	62.3%	38.9%	-23.4	66.3%	93.9%	27.6	57.0%	80.3%	23.3
	E																		
	TOTAL	33.3%	53.5%	20.2	22.1%	91.9%	69.8	82.5%	86.7%	4.2	58.3%	32.7%	-25.6	65.4%	92.9%	27.5	52.4%	71.5%	19.1
#9. Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary[5]	C	100.0%	0.0%	-100.0	CNC	100.0%	N/A	100.0%	100.0%	0.0	0.0	50.0%	50.0	CNC	100.0%	N/A	60.0%	83.3%	23.3
	D	0.0%	CNC	N/A	66.7%	100.0%	33.3	87.5%	100.0%	12.5	100.0%	100.0%	0.0	50.0%	88.9%	38.9	72.7%	98.2%	25.5
	E	60.9%	33.3%	-27.6	100.0%	100.0%	0.0	85.0%	100.0%	15.0	81.8%	50.0%	-31.8	62.5%	100.0%	37.5	76.3%	94.0%	17.7
	TOTAL	60.0%	16.7%	-43.3	85.7%	100.0%	14.3	86.7%	100.0%	13.3	76.9%	75.0%	-1.9	61.1%	96.6%	35.5	75.0%	93.8%	18.8
#9a. Member's plan of care is amended based on change of member condition[6]	C	0.0%	0.0%	0.0	0.0%	100.0%	100.0	40.0%	100.0%	60.0	CNC	75.0%	N/A	CNC	100.0%	N/A	25.0%	77.8%	52.8
	D	100.0%	50.0%	-50.0	41.7%	100.0%	58.3	100.0%	100.0%	0.0	CNC	83.3%	N/A	50.0%	0.0%	-50.0	65.4%	82.6%	17.2
	E	100.0%	CNC	N/A	66.7%	CNC	N/A	100.0%	100.0%	0.0	0.0%	33.3%	33.3	100.0%	100.0%	0.0	84.6%	60.0%	-24.6
	TOTAL	66.7%	33.3%	-33.4	41.2%	100.0%	58.8	84.2%	100.0%	15.8	0.0%	73.7%	73.7	71.4%	75.0%	3.6	63.8%	78.4%	14.6
#10. Plans of care are aligned with members needs based on the results of the NJ Choice Assessment[7]	C	100.0%	98.4%	-1.6	60.9%	100.0%	39.1	100.0%	100.0%	0.0	87.5%	87.5%	0.0	83.3%	100.0%	16.7	89.5%	96.6%	7.1
	D	88.0%	100.0%	12.0	36.8%	100.0%	63.2	100.0%	100.0%	0.0	96.3%	100.0%	3.7	97.4%	100.0%	2.6	84.2%	100.0%	15.8
	E	100.0%	88.0%	-12.0	100.0%	100.0%	0.0	100.0%	100.0%	0.0	81.8%	88.9%	7.1	100.0%	100.0%	0.0	96.2%	95.5%	-0.7
	TOTAL	97.0%	96.0%	-1.0	55.0%	100.0%	45.0	100.0%	100.0%	0.0	91.0%	93.0%	2.0	97.0%	100.0%	3.0	88.0%	97.8%	9.8
#11. Plans of care developed using "person-centered principles"[8]	C	7.7%	0.0%	-7.7	30.4%	100.0%	69.6	5.3%	55.6%	50.3	0.0%	3.1%	3.1	0.0%	100.0%	100.0	9.7%	31.3%	21.6
	D	4.0%	0.0%	-4.0	7.0%	100.0%	93.0	3.3%	69.1%	65.8	0.0%	2.4%	2.4	1.3%	100.0%	98.7	2.9%	68.6%	65.7
	E	0.0%	0.0%	0.0	90.0%	100.0%	10.0	0.0%	51.9%	51.9	0.0%	0.0%	0.0	0.0%	100.0%	100.0	17.0%	50.8%	33.8

Performance Measure	ABHNJ				AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[1]		
	Group[2]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]	7/17 to 6/18	7/18 to 6/19	PPD[3]
	TOTAL	5.0%	0.0%	-5.0	29.0%	100.0%	71.0	3.0%	62.0%	59.0	0.0%	2.0%	2.0	1.0%	100.0%	99.0	7.6%	52.9%	45.3
#12. MLTSS Home and Community-Based Services (HCBS) plans of care that contain a back-up plan[9]	C	87.9%	82.6%	-5.3	9.1%	0.0%	-9.1	100.0%	91.7%	-8.3	100.0%	89.5%	-10.5	100.0%	100.0%	0.0	81.1%	71.0%	-10.1
	D	72.0%	63.6%	-8.4	8.9%	4.0%	-4.9	96.4%	98.1%	1.7	96.3%	94.7%	-1.6	92.1%	100.0%	7.9	74.5%	74.3%	-0.2
	E	85.0%	85.0%	0.0	21.4%	0.0%	-21.4	100.0%	91.3%	-8.7	92.9%	83.3%	-9.6	94.4%	100.0%	5.6	81.2%	71.4%	-9.8
	TOTAL	82.1%	80.5%	-1.6	11.1%	2.1%	-9.0	97.7%	95.5%	-2.2	96.3%	90.7%	-5.6	92.8%	100.0%	7.2	77.0%	72.7%	-4.3
#16. Member training on identifying/reporting critical incidents	C	98.1%	72.6%	-25.5	91.3%	100.0%	8.7	94.7%	100.0%	5.3	100.0%	87.5%	-12.5	100.0%	100.0%	0.0	96.8%	85.7%	-11.1
	D	88.0%	75.0%	-13.0	96.5%	98.0%	1.5	100.0%	100.0%	0.0	98.1%	97.6%	-0.5	96.1%	100.0%	3.9	96.7%	97.7%	1.0
	E	95.8%	68.0%	-27.8	95.0%	100.0%	5.0	100.0%	100.0%	0.0	81.8%	88.9%	7.1	100.0%	100.0%	0.0	94.3%	91.7%	-2.6
	TOTAL	95.0%	71.7%	-23.3	95.0%	99.0%	4.0	99.0%	100.0%	1.0	95.0%	92.0%	-3.0	97.0%	100.0%	3.0	96.2%	92.6%	-3.6

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

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

[3] Percentage point difference.

[4] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care.

[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 plan of care (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 from this measure.

CNC: Could not calculate; N/A: Not applicable

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

ABHNJ

Total results of ABHNJ's 7/1/2018–6/30/2019 MLTSS PMs ranged from 0.0% to 96.0% across all groups for all seven (7) performance measures for the current review period (**Table 11**).

Overall, the MCO demonstrated improvement of 5%or more in one (1) of the seven (7) performance measures:
• #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (20.2%)

Overall, the MCO demonstrated declines of 5% or more in four (4) of the seven (7) performance measures:
• #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (-43.3%)
• #9a. Member's Plan of Care is amended based on change of member condition (-33.4%)
• #11. Plans of Care developed using "person-centered principles" (-5.0%)
• #16. Member training on identifying/reporting critical incidents (-23.3%)

AGNJ

Total results of AGNJ's 7/1/2018–6/30/2019 MLTSS PMs ranged from 2.1% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 11**).

Overall, the MCO demonstrated improvement of 5% or more in five (5) of the seven (7) performance measures:
• #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (69.8%)
• #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (14.3%)
• #9a. Member's Plan of Care is amended based on change of member condition (58.8%)
• #10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment (45.0%)
• #11. Plans of Care developed using "person-centered principles" (71.0%)

Overall, the MCO demonstrated declines of 5% or more in one (1) of the seven (7) performance measures:
• #12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan (-9.0%)

HNJH

Total results of HNJH's 7/1/2018–6/30/2019 MLTSS PMs ranged from ranged from 62.0% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 11**).

Overall, the MCO demonstrated improvement of 5% or more in three (3) of the seven (7) performance measures:
• #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (13.3%)
• #9a. Member's Plan of Care is amended based on change of member condition (15.8%)
• #11. Plans of Care developed using "person-centered principles" (59.0%)

Overall, the MCO did not demonstrate any declines of 5% or more the seven (7) performance measures.

UHCCP

Total results of UHCCP's 7/1/2018–6/30/2019 MLTSS PMs ranged from 2.0% to 93.0% across all groups for all seven (7) performance measures for the current review period (**Table 11**).

Overall, the MCO demonstrated improvement of 5% or more in one (1) of the seven (7) performance measures:
• #9a. Member's Plan of Care is amended based on change of member condition (73.7%)

Overall, the MCO demonstrated declines of 5% or more in two (2) of the seven (7) performance measures.
• #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (-25.6%)
• #12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan (-5.6%)

WCHP

Total results of WCHP's 7/1/2018–6/30/2019 MLTSS PMs ranged from 75.0% to 100.0% across all groups for all seven (7) performance measures for the current review period (**Table 11**).

Overall, the MCO demonstrated improvement of 5% or more in four (4) of the seven (7) performance measures.
• #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS (27.5 %)
• #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary (35.5%)
• #11. Plans of Care developed using "person-centered principles" (99.0%)
• #12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan (7.2%)

Overall, the MCO did not demonstrate declines of 5% or more in any of the seven (7) performance measures.

2019 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 the MCO Contract are consistent with professionally recognized standards of care. IPRO prepared an audit tool based on the DMAHS MCO Contracts (Article 9) dated July 2017 and January 2018. 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 7/1/2017 through 6/30/2018.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, POC 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 7/1/2017 through 6/30/2018 (Group 1), MLTSS members residing in an NF/SCNF for at least six consecutive months between 7/1/2017 and 6/30/2018 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 7/1/2017 and 6/30/2018 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 12 displays MCO results based on care management file review for the period of 7/1/2017–6/30/2018. The reported rates include members from Groups 1 and 2. Results were limited due to the low volume of members identified in Group 2, and the absence of members in Groups 3 and 4. UHCCP was the only MCO that had members identified in Group 2. Based on file review, none of the MCOs had members in Group 3 or 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.

All five MCOs scored at or above 98% for "MLTSS plans of care on file" and all MCOs scored at or above 97% for "Members present at each onsite visit." All five MCOs scored at or above 86% for "Members identified for transfer to HCBS." Three MCOs scored at or above 95% for "Member and/or representative participated in the development of goals." Four MCOs scored at or above 89% for "New Jersey Choice Assessment completed during the review period." Four MCOs scored at or above 88% for "Care manager completed or confirmed PASRR Level I and Level II, if applicable prior to transfer to NF/SCNF."

Four MCOs have an opportunity for improvement in the following elements: care manager's participation in at least one facility interdisciplinary team (IDT) meeting (scores ranged from 11% to 75% for four MCOs); copies of any facility plans of care on file (scores ranged from 66% to 79% for four MCOs); and documented review of the facility plan of care (scores ranged from 37% to 79% for four MCOs). Three MCOs have an opportunity for improvement in the following element: completion of initial plan of care (scores ranged from 9% to 27% for three MCOs).

Only one MCO had a member that fell in the "Members who transitioned from a NF/SCNF to HCBS"; therefore, a comparison could not be made across MCOs. The MCO documented a discussion with the member prior to change of service/placement.

Table 12: MLTSS NF Care Management Audit Results for 7/1/2017–6/30/2018

Category	2018 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Facility and MCO Plan of Care															
Member's care management record contained **copies of any facility plans of care on file** during the review period	77	100	77%	78	100	78%	79	100	79%	66	100	66%	87	100	87%
Documented review of the facility plan of care by the care manager	67	100	67%	78	100	78%	79	100	79%	37	100	37%	87	100	87%
MLTSS plan of care on file includes information from the facility plan of care	73	73	100%	76	77	99%	79	80	99%	56	57	98%	31	31	100%
Plan of Care Development															
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the member and/or representative within 45 calendar days of enrollment into the MLTSS program (for members newly enrolled in managed care and newly eligible for MLTSS during the review period)	5	58	9%	33	35	94%	39	40	98%	5	26	19%	12	44	27%
Agreement/Disagreement statements from the plan(s) of care on file during the review period were reviewed with the member and/or representative at each visit	59	100	59%	97	100	97.0%	97	100	97%	70	100	70%	30	100	30%
Written Member Goals Include All 5 Components: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 – reviewed at each visit and documented progress)	95	100	95%	95	100	95%	100	100	100%	64	100	64%	32	100	32%
Plan of Care Addresses Formal and Informal Services: Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the plan of care, including the coordination of formal and informal services	95	100	95%	98	100	98%	100	100	100%	83	100	83%	30	100	30%
Plan of Care Developed with Person-Centered Principles: POC documentation reflected a member-centric approach demonstrating the involvement of the member and/or representative in the development of his/her goals	95	100	95%	97	100	97%	100	100	100%	72	100	72%	29	100	29%
Member and/or representative participated in the development of goals	95	100	95%	97	100	97%	100	100	100%	76	100	76%	29	100	29%
Transition Planning															

Category	2018 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community	97	100	97%	100	100	100%	100	100	100%	93	100	93%	86	100	86%
Evidence of the **care manager's participation in at least one facility interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one member visit.)	12	100	12%	33	100	33%	94	100	94%	11	100	11%	75	100	75%
Timely Onsite Review of Member Placement and Services: Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF members or at least 90 calendar days for pediatric SCNF members. (Member's presence at these visits was required regardless of cognitive capability)	21	100	21%	48	100	48%	68	100	68%	19	100	19%	28	100	28%
Member was present at each onsite visit or had involvement from the member's authorized representative regarding the plan of care. (If the member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the member did not have a legal guardian or representative, this requirement was not applicable)	97	97	100%	99	100	99%	100	100	100%	98	98	100%	90	93	97%
Members requiring coordination of care had **coordination of care** by the care manager	4	4	100%	90	99	91%	97	97	100%	1	2	50%	81	97	84%
Care manager explained and discussed any payment liability with the member if a member had any payment liability for the NF/SCNF admission	0	0	N/A	0	0	N/A	97	97	100%	0	0	N/A	73	73	100%
Reassessment of the POC and Critical Incident Reporting															
Updated Plan of Care for a Significant Change: For any significant change in member condition, member's plan of care was updated, reviewed and signed by the member and/or representative, and a copy was provided to the member and/or representative	1	6	17%	3	3	100%	6	6	100%	2	23	9%	0	2	0%
Member had a **New Jersey Choice Assessment completed** during the review period	93	100	93%	90	99	91%	100	100	100%	89	100	89%	74	100	74%
NJCA completed for members newly enrolled in managed care and newly eligible for MLTSS during the review period	48	51	94%	16	19	84%	24	24	100%	25	27	93%	32	36	89%
NJCA completed for members enrolled in MLTSS with the MCO prior to the review period	45	49	92%	74	80	93%	76	76	100%	64	73	88%	42	64	66%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	89	100	89%	96	100	96%	82	100	82%	63	100	63%	81	100	81%

Category	2018 Total Rates														
	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
PASRR Communication for Transitions to/from NF/SCNF															
Member was admitted to a NF/SCNF prior to the review period	94 Members (94%)			92 Members (92%)			85 Members (85%)			92 Members (92%)			89 Members (89%)		
Member was admitted to an NF/SCNF during the review period	6 members (6%)			8 members (6%)			15 members (15%)			8 members (8%)			11 members (11%)		
Care manager completed or confirmed PASRR Level I and Level II, if applicable prior to transfer to NF/SCNF	6	6	100%	5	8	63%	15	15	100%	7	8	88%	11	11	100%
Communication of PASRR Level I to OCCO through an NJCA by care manager	5	6	83%	4	8	50%	15	15	100%	5	8	63%	11	11	100%
Communication of PASRR Level II to OCCO through an NJCA by care manager	1	1	100%	1	2	50%	5	5	100%	1	2	50%	0	0	N/A
Members who had PASSR Level II forms indicating a need for **specialized services setting was coordinated appropriately with DDD/DMAHS**	0	0	N/A	1	2	50%	5	5	100%	1	1	100%	0	0	N/A
NF/SCNF Member Transferred to HCBS (Groups 2, 4)															
NJCA was completed to assess the member's needs prior to discharge from a NF/SCNF	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Cost effectiveness evaluation was completed for the member prior to discharge from a NF/SCNF	0	0	N/A	0	0	N/A	0	0	N/A	0	1	0%	0	0	N/A
Plan of Care Updated Prior to Discharge from a Facility: plan of care was developed and agreed upon by the member and/or representative prior to the effective date of transfer to the community	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Person-centered transition plan of care on file for the member	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Participation in an IDT-related to Transition: Care manager participated in the coordination of an interdisciplinary team meeting (IDT) related to transition planning	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Authorizations and procurement of transitional services for the member were done prior to NF/SCNF transfer	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the member's plan of care	0	0	N/A	0	0	N/A	0	0	N/A	1	1	100%	0	0	N/A
Care manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	N/A	0	0	N/A	0	0	N/A	0	1	0%	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 July 1, 2017 to June 30, 2018. 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 July 1, 2017 to June 30, 2018 QTR recommendations as follows:

- *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.*

ABHNJ will continue to look at member disparities based on internal data overlaid by external data. ABHNJ will make improvements to our population assessment to assure subpopulations such as members with Severe Mental Illness, Adolescents and the Aged, Blind and Disabled populations are specifically called out. This is in addition to findings within all other populations will drive a comprehensive needs assessment. The Health Plan will assess top diagnosis, top medications, ER and IP utilization for each sub-population. This internal analysis will be laid over state social determinants of health data to identify opportunities. The health Plan will look to address these opportunities in the Population Health Strategy in 2020.

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

ABHNJ's ongoing recruitment of Pediatrician's has led to the contracting of 121 Pediatric PCPs statewide from July 1, 2018 through June 30, 2019. The results of Q2 Geo Access reports are outlined below determine the plan is adequate in all counties for Pediatric PCPs. Recruitment of Pediatric PCPs continue statewide.

County	Q2 - June 2019 Geo Access Results Pediatric Primary Care
Atlantic	95.7%
Bergen	100.0%
Burlington	99.8%
Camden	100.0%
Cape May	100.0%
Cumberland	95.0%
Essex	100.0%
Gloucester	95.3%
Hudson	100.0%
Hunterdon	100.0%
Mercer	98.8%
Middlesex	100.0%
Monmouth	97.6%
Morris	97.2%
Ocean	98.3%
Passaic	98.9%
Salem	100.0%
Somerset	98.4%
Sussex	100.0%
Union	100.0%
Warren	97.9%

DentaQuest continues to recruit dentists in the deficient counties. ABHNJ has made plans to switch to a new dental vendor on May 1, 2020 pending approval by the State of New Jersey. The new vendor will offer a larger network which will be compliant in all 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.*

ABHNJ has initiated contracts for Medical Day Care Center providers for the following counties:
Cape May County – The plan has verified there is one Medical Day provider in Cape May County, who is currently contracted. A network exception will be requested Q1 2020.

- Active Day of Cape May - contracted 12/1/2018

Hunterdon County - The plan has verified one Medical Day Care provider in the County. Currently pursuing a contract with Flemington Adult Day Care Center. A network exception will be requested Q1 2020.

- Visiting Nurse Association of Northern NJ – contracted 12/1/2014

Sussex County - The plan has verified that they are no Medical Day Care Center providers in the Salem County. A network exception will be requested Q1 2020.

Warren County - The plan has verified that they are no Medical Day Care Center providers in the Warren County. A network exception will be requested Q1 2020.

The Health Plan has initiated contracts with Social Adult Day Care Center providers for the following county:
Cape May County - The plan has verified there are no Social Adult Day Care Center providers in the Cape May County. A network exception will be requested Q1 2020.

Hunterdon County - The plan has verified one Social Adult Day Care Center provider in Hunterdon County. Currently pursuing a contract with Brightside Adult Day Care. A network exception will be requested Q1 2020.

- Brightside Adult Day Care – affiliated with Hunterdon Healthcare

Somerset County – The plan is contracted with two Social Adult Day Care Center providers in Somerset County.

- New Life Adult Social Daycare - contracted 9/1/2019
- Adult Day Center of Somerset County – contracted 9/1/2019

Sussex County - The plan has verified that they are no Social Adult Day Care Center providers in Sussex County. A network exception will be requested Q1 2020.

Warren County - The plan has verified that they are no Social Adult Day Care Center providers in the County. A network exception will be requested Q1 2020.

The Health Plan is contracted with 2 of 3 facilities which offer Structured Day Program providers in the State of New Jersey. The following providers offer structured days services Statewide:

- Servicing all counties - contracted - Neuro Restorative
- Servicing all counties - contracted - Bancroft NeuroRehab

- *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.*

ABHNJ has partnered with a third-party vendor to complete the telephonic outreach portion of the Appointment Availability Survey. A comprehensive methodology has been developed to sample providers in the required provider types (Primary Care, Behavioral Healthcare, and Specialty Care) to be sampled. ABHNJ has created a detailed tracking mechanism to document the results of the calls and identify next steps for each provider. The providers who fail to meet the appointment availability

parameters outlined in the State contract will be sent a letter notifying them of the result and will be provided education of their contractual obligations. The providers will then be re-surveyed to assure compliance.

- *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.*

ABHNJ made significant strides in the development, refinement and ultimately distributed a suite of Elderly and Disabled reports in fiscal year 2019. Reports were distributed to the top 10 providers in each reporting category on a quarterly basis. In 2020, ABHNJ will seek out IT solutions that allow for network wide distribution of internal data for all Elderly and Disabled reporting. A quarterly Elderly and Disabled work group was developed in 2019 which drove the current improvements. The work group will continue to meet in 2020 with the goal of developing a process that allows for network wide distribution of reports as well as to identify trends within the membership and network to address identified issues in a meaningful way.

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

In this last calendar year, ABHNJ has added two additional team members (one clinician, one non-clinical) to assist in the growing volume of cases and overall needs of the department and plan. This has resulted in a sharp decline in untimely cases. Additionally, this calendar year, Aetna Better Health has begun internal audits of all Grievance and Appeal Cases. These audits are reviewed bi-weekly with our Grievance and Appeal national team.

The Grievance and Appeal Team has also consolidated our case referral sources. Other teams within Aetna will contact a single, monitored, departmental email box rather than attempt to contact individual team members. This has been reviewed with these teams during their recent, robust annual trainings on identifying and referring appeal and grievance cases.

- *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 has developed, submitted and received approval on the 2019 HEDIS workplan. Within the workplan several new initiatives focused on improving HEDIS results were outlined. These initiatives include IVR call and text message campaigns that are focused on gap closure and wellness. IVR campaigns include Adult Preventative Care, Dental Care, Lead Screening, Well-Child reminders and Postpartum care reminders. Text message campaigns include, but are not limited to Text4Baby, Care4Life, Text2Quit and Text4Health. Additionally, ABHNJ has implemented a pilot project meant to enhance provider relationships and cultivate partnerships around improving outcomes. These relationships consist of an on-site HEDIS coordinator who brings expertise on how to use gap in care reports, develops provider specific reports broken down by age to assure services are provided timely, provides claim transparency and opportunities to collect medical records for review and submission to our Quality Management Nurse consultant. These initiatives are supplemented by personalized mailers sent to providers who have members included in the denominator for the following measures; Monitoring for patients on Persistent Medication (MPM), Follow up care for children prescribed ADHD medications (ADHD), Diabetes monitoring for People with Schizophrenia or Bipolar Disorder who are taking Antipsychotic Medications (SSD) and diabetes monitoring for people with diabetes and Schizophrenia (SMD).

- *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.*

ABHNJ hired a master's prepared RN for the clinical lead role. This role was created to assure that ABHNJ had the necessary staffing in order to effectively implement and monitor all Performance Improvement Projects (PIP). Additionally, ABHNJ has developed a quarterly PIP meeting to review the progress of each PIP intervention and outcome

measurement with the leadership team. Special attention is being paid to the develop of PIPs in order to assure that interventions can be operationalized in a timely manner.

- *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 will continue to ensure timely outreach to members in order to complete the individual health screener (IHS) for newly enrolled General Population members. As of 2018 to present day, Integrated Care Management began utilizing an Integrated Voice Recognition (IVR) system, called Eliza, to assist in completing outreach to members that are newly enrolled into ABHNJ to complete the I.H.S. The ICM team receives the Eliza results daily and processes those results into our Dynamo Case Tracker care management system for them to be triaged for care management needs. If the member cannot be reached after 3 call attempts, by our automated system, a paper I.H.S. is mailed out to the member with a prepaid envelope. Blank I.H.S. forms will also be added to the welcome packet that a member receives when they are newly enrolled into an ABHNJ plan. As an ongoing effort, if any members are referred to Care Management and do not have an I.H.S. on file, all staff are trained and required to complete an I.H.S., if member is reached and engaged for care management services.

ABHNJ will continue to ensure that timely and adequate attempt are made to reach members for completion of the Comprehensive Needs Assessment (CNA) when potential CM needs are identified through completion of the I.H.S. or other sources (such as internal or external referrals, pharmacy reports, utilization reports, etc). Resources are now devoted to audit every case that is assigned to a clinician on the care management team, either in Intensive or Supportive: Standard level of care. Cases are audited, in entirety, for documentation precision, timeliness, aggressive outreach, preventative health, clinical clarity, as well as accurate assessment of the member's needs.

- *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.*

MLTSS QM Liaison continues to randomly audit MLTSS member records on a monthly basis to ensure compliance with member centric, person centered care planning, and risk assessment completion/identification is completed. The MLTSS team meets with QM quarterly to review trends and identify areas of process improvement and training needs. ABHNJ MLTSS plan of care was state approved and updated on 5/10/2019. The updated version continues to include all contractual essential elements which include member and/or member representative involvement in plan of care, unmet needs, risk factors, member preferences, and caregiver needs.

MLTSS CM staff are required to receive member centric, person centered plan of care training upon initial hire and ongoing throughout the year.

Face to face visit documentation templates include name and relationship of those present during visit.
ABHNJ created new document which was state approved on 6/13/2019 that includes statement tailored for MLTSS members indicating that they received, reviewed, and understood rights and responsibilities. All MLTSS CM staff were trained on using this document in June 2019 and it has been included in all face to face visit workflows. The document can be generated in the members electronic record. In addition, the MLTSS QM Liaison and LTSS supervisory team confirm completion during record audits and continues to monitor compliance.

- *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.*

MLTSS NF plans of care are requested by the MLTSS support team upon initial member enrollment.

MLTSS NF CM workflows include review of members electronic record to confirm receipt of most current NF plan of care prior to each visit. If not received CM is to request during each face to face visit at the NF and attach a copy to the members electronic record.

MLTSS NF face to face visit documentation templates require CM to confirm receipt of NF plan of care, document review, obtain date of next IDT, and educate staff on inviting MLTSS CM to participate in IDT. In addition, workflows include that all CM are required to leave contact information at the facility for staff to contact CM.

MLTSS support team works with CM team to assist in scheduling NF IDT meetings and insert meeting dates in CM calendars. In addition, the MLTSS support team adds alerts to the members record to prompt and remind of next IDT date.

Informatics runs monthly report and collects information regarding member NF IDT events. These events are created in the electronic record to capture NF IDT date and documentation. This information is dispersed to the support team and CM's to assist with scheduling members in need of annual NF IDT. In addition, supervisory staff can monitor the MLTSS dashboard which includes dates of NF IDT and placement information. This information is reviewed with staff during meetings with supervisors to confirm compliance and outstanding IDTS visits needed.

Informatics runs monthly report and collects information regarding timely face to face NF visits. This report is used by the supervisory team to monitor timely onsite review visit and is reviewed with direct reports during meetings to confirm compliance with required face to face visits.

MLTSS QM Liaison continues to randomly audit MLTSS NF member records on a monthly basis to ensure compliance with review of NF plan of care and participation in facility IDT meetings. The MLTSS team meets with QM quarterly to review trends and identify areas of process improvement and training needs.

NF contacting CM has been identified as a barrier to attending NF IDT. MLTSS CM team is working with MLTSS provider rep to enhance provider training on contractual requirement.

AGNJ

AGNJ addressed IPRO's July 1, 2017 to June 30, 2018 QTR recommendations as follows:

- *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.*

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. To date, Amerigroup is still pending a response to this request.

Hunterdon Medical Center (HMC) refuses to contract with another Medicaid MCO despite numerous attempts made by Amerigroup to do so. HMC is the only hospital in this county and employs most of the physicians. The most recent outreach was in April 2019. As a result of the Hospital's position, the physicians affiliated with the hospital-affiliated IPA will also not contract with Amerigroup.

2. Adult PCPs and Pediatricians/Warren
Amerigroup has been focused on curing deficiencies within the county in the geographic areas of Phillipsburg 08865, Columbia 07832, and Blairstown 07825. The ability to recruit has been challenged by St. Luke's Hospital-Warren Campus non-participation and its acquisition of many of the PCP practices in these areas. Our recruitment efforts have uncovered that the majority of the PCP practices, as well as many of the specialist practices, are owned by the hospital system. Despite numerous outreach attempts, the hospital has not committed to a full contract. Amerigroup re-initiated the contract discussion in December 2019 but based on the preliminary status of those conversations and history of unresponsiveness, Amerigroup will request for a waiver for Warren county.

3. Endocrinologists/Warren
As of 1Q2019, there is no longer a deficiency. This is primarily attributable to the recruitment of Atlantic Medical Group, which has eight (8) endocrinologists with a location in Flemington which is in neighboring Hunterdon county and is within the geo access requirement of 45 miles.

4. Hospitals:
Amerigroup continues to seek to contract with acute care hospitals that remain non-participating with the plan, in an effort to improve both hospital and physician adequacy. Most significantly, Amerigroup is in an active negotiation with the Hackensack Meridian Health system although it is unclear if the parties will be able to agree on a system wide contract at this time. Additionally, the Plan continues to attempt to engage with Hunterdon Medical Center despite past refusals by this hospital to contract with another Medicaid MCO as well as St. Luke's Warren Hospital who has not engaged substantively in contract discussions in recent years. Amerigroup will continue efforts and outreach.

5. Dental:
As of the 2019 3rd quarter, for PCDs Amerigroup had 100% GEO access for all counties except Atlantic county which was at 92.7%. For Pedodontists, Amerigroup had 100% GEO access in all counties except as follows: Atlantic 90.1%; Monmouth 97.8%; and Morris 91.0%. All of these figures meet the requirements for urban and non-urban counties. Amerigroup currently utilizes the services of Liberty Dental as our Dental vendor. 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 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.*

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

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

Amerigroup continues to stay focused on continually improving after-hours access to care for our Members.
To ensure compliance with State regulations, Amerigroup conducts an annual After Hours audit. As a result of outreach efforts to educate providers about the access to care standards and our requirement that noncompliant providers supply written corrective action plans, Amerigroup achieved improved compliance rates for the most recent survey conducted in June 2019. The fully-compliant rate increased by 12% up to 80%.

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

Amerigroup continues to stay focused on continually improving appointment availability for our Members.
To ensure compliance with State regulations, Amerigroup conducts an annual Appointment Availability audit. As a result of outreach efforts to educate providers about the access to care standards and our requirement that noncompliant providers supply written corrective action plans, Amerigroup achieved improved compliance rates for the most recent survey conducted in June 2019. The fully-compliant rate increased by 18% up to 95%.

- *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 continues to maintain a work plan to track NCQA measures that fall below the 50th percentile. Cross departmental workgroup meetings will continue to be held throughout 2020 to analyze and address specific measures, and benchmark reporting will also continue to be reviewed monthly to monitor rates. Amerigroup has developed additional reports to assist with analyzing and identifying new opportunities to drive outcomes. For measures that have been consistently measured year to year, Amerigroup continues to notice improvement in the majority of measures. Amerigroup has been the only NJ Medicaid health plan attaining Commendable NCQA status 3 years in a row.

- *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.*

Amerigroup continues to hold PIP specific workgroup meetings to ensure ongoing engagement and timely interventions across key departments. QM implemented a PIP monitoring work plan to track interventions and data /reporting needs in 1Q19 and will continue to maintain and monitor the plan in 2020 to identify opportunities to further improve its internal processes.

- *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.*

Amerigroup MLTSS is utilizing a Care Management production report – this report pulls all members, by Care Manager assignment, due for a visit, annual NJCA, plan of care review, etc. The report continues to be sent to each Amerigroup case manager monthly and an aggregate summary is distributed to the assigned manager and their clinical director. This report is refreshed on a weekly basis to monitor progress with upcoming cases. The report also notifies CMs of overdue visit and overdue completion of Plan of Care.

Amerigroup is in the process of including the back-up plan to this report for monitoring compliance. This will provide management an opportunity to conduct reeducation with staff in a group setting and/or one on one.

During 2018 and 2019, Amerigroup field Care Management staff attended Person Centered Thinking training on a person-centered approach to care planning. Included in this education was necessary revisions of member-centric goals, member participation in Plan of Care review, prioritization of goals, cultural and linguistic needs, etc. Amerigroup Care Managers currently utilize a face-to-face visit template to specifically capture that the member/member representative were present during the development of goals and in agreement with the established goals. Clinical Managers conduct weekly Team Huddles including a review of a random sample Plan of Care to create an opportunity for reeducation when documentation does not meet standards.

Amerigroup has faced technical challenges in our current clinical system in capturing the member's signature on all documents, including the MLTSS Plan of Care, Risk Agreement, and Back-up Plan. In 2020, Amerigroup will be transitioning to a new platform, Healthy Innovations Platform (HIP), a new and updated clinical system, which will allow the Care Manager to capture the member signature on all assessments.

- *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.*

Amerigroup MLTSS continues to dedicate specific Care Managers to manage the care of members residing in Nursing Facilities and Assisted Living Residences. Case managers are assigned by facility, therefore promoting the MCO/CM relationship with the facility staff and allowing Care Managers to educate facility representatives on the importance of CM notification of facility IDT dates. This has increased CM ability and capacity to attend facility IDT meetings.

The management team remains aligned to ensure one manager oversees the CM Nursing Facility Team. This dedicated manager provides ongoing comprehensive overviews of updated case management processes for members in an institutionalized setting. All workflows/notes outlining these processes are maintained and updated by the dedicated manager and are available for the team for review at any time in a central, shared location.

As part of the realignment process, Amerigroup also dedicated two non-clinical staff to support facility case management.

Amerigroup Care Managers currently utilize a face-to-face visit template to include clear documentation that the facility Plans of Care are obtained and reviewed by the Care Manager during each visit, as well as saved into member's electronic record. The dedicated Facility Team clinical manager is reinforcing documentation of collection and review of the Nursing Facility POC during weekly team huddles and monthly case management meetings. Amerigroup continues to ensure this element is included in manager medical record audits.

Amerigroup utilizes a database that pulls face to face contact note narratives for reporting purposes to measure compliance with this documentation. Results of this reporting is utilized for reeducation of staff in a group and one on one basis.

In 2020, Amerigroup will be transitioning to a new platform, Healthy Innovations Platform (HIP), a new and updated clinical system, which will assist in supporting non-clinical staff to screen all facility members for compliance to this documentation – currently this requires a manual review.

HNJH

HNJH addressed IPRO's July 1, 2017 to June 30, 2018 QTR recommendations as follows:

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

To ensure that ongoing evaluation of the Horizon action plan implemented in 2017 related to cancer screenings in Efforts to Reduce Healthcare Disparities, the action plan that was developed in 2016, and implemented in July 2017 continues to be utilized through 2019. 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 via the Healthcare Disparities Workplan. Updates are reported monthly at the Healthcare Disparities Workgroup and quarterly at the Quality Improvement Committee.

Specific to Cancer Screenings, Horizon has taken the following actions to evaluate the action implemented in 2017:

1. Conduct quantitative and qualitative analysis of interventions implemented in 2017
2. Complete work plan and detailed report for interventions implemented in 2017
3. Reassessment of barriers identified for 2017 interventions
4. Identification of continuing or new interventions for 2018
5. Conduct monitoring evaluation of continuous interventions
6. Conduct quantitative and qualitative analysis of all interventions implemented in 2018
7. Complete work plan and detailed report for all interventions implemented in 2018
8. Reassessment of barriers identified for 2018 interventions
9. Identification of continuing or new interventions for 2019

- *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 address areas where clinical performance was subpar in comparison to the NCQA benchmarks, Horizon continues to work on HEDIS performance improvement to achieve a minimum of NCQA HEDIS 50th percentile for all contract performance measures. The measures that fall below HEDIS 50th percentile are included in the HEDIS Work Plan, submitted to DMAHS annually.
A barrier analysis is conducted for each measure included on the work plan, and strategy to address the barriers is developed. The interventions and activities are strategically implemented and outcomes tracked to ensure effectiveness. Upon receipt of any feedback, additional actions are developed and the Workplan adjusted to address the opportunities presented.

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

To address the timeliness opportunities identified in the MRR chase, Horizon has enlisted multiple activities to ensure that medical records are received and reviewed in a timely manner. These activities include efforts that have been initiated and will continue for the future:

1. Communicating HEDIS updates now with providers to reinforce expectations during HEDIS chart chase season
2. Outreach by Clinical Quality Improvement Liaisons confirming provider staff responsible for HEDIS
3. Hired call center representatives to contact providers ongoing during chart chase until requested records received
4. Hired contract nurses to work with full-time staff to review medical records and follow-up with providers
5. Use of bi-directional platform to send HEDIS requests and receive charts from providers
6. Onboarding of all contract workers first week in January for measure and technical training
7. Daily reporting to include charts received, charts reviewed and over-reads completed
8. Implementing business process improvement plans formulated during HEDIS 2019 post-mortem

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

To address the opportunities identified with the HEDIS Warehouse, Horizon has determined that it would be a valuable effort to move to a new HEDIS vendor for HEDIS 2020. We have been working closely in conjunction with Inovalon as it relates to the software implementation. These activities include evaluation and validation of all source systems that flow to a single

warehouse. In addition, the team is conducting end to end comprehensive testing of data elements and robust documentation of workflows, policies and procedures. In parallel, the teams meet daily to discuss any data anomalies discovered with the goal to eliminate or mitigate issues discovered.

- *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*

To 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, Horizon will continue to work and improve the reporting capabilities we use to identify members with potential care management needs. Horizon launched a pilot program that identifies a member's risk for readmission, and is used as a trigger to outreach for community based case management and/or bedside outreach in 2017 and is ongoing. Additionally, we continue to utilize reporting previously established, such as the Personal Care Assistant report, Diaper Report, Emergency Room Report, Inpatient Report, Under/Over Utilization Report, Dental Emergency Room Utilization Report and the HbA1c Report.

- *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.*

Horizon develops the MLTSS members' Plan of Care (POC) with the member using person-centered principals. Once the POC is developed, it is signed by the member or his/her personal representative and the Care Manager. Copies of POC are provided to members once they have been completed. In July 2018, Horizon instituted the new POC requirements per contract, to enhance the person-centered approach and to add additional information to ensure members goals and needs are being met. Additional training was completed for all Care Managers in 2018 on SMART goals and utilization of the SMART goals in POC development.

Ongoing tracking and reports allow additional follow up with members/personal representatives to ensure signed copies of POC are received timely. Care Managers have also been educated to provide members/personal representatives the opportunity to provide signatures while they are in the member's home if they are able. Additionally, all MLTSS members annually sign off that they have received and understand their rights and responsibilities.

- *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.*

To ensure inclusion of copies of MLTSS NF plans of care in the MCO care management file, Horizon has transitioned to assigning a specific MLTSS Nursing Facility Care Managers in each facility, which allows for workflows to be consistent for all membership. This has enabled relationships between Horizon MLTSS CM's and facility staff to develop. Horizon has also provided additional training to nursing facility staff to make them aware of the documents we require for MLTSS members. In executing these changes, we have been successful in obtaining copies of and reviewing Nursing Facility Plans of Care as required. We continue monitoring to ensure that we are compliant with this requirement.

UHCCP

UHCCP addressed IPRO's July 1, 2017 to June 30, 2018 QTR recommendations as follows:

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

The plan continues to make outreach to all non-contracted pediatric specialists and acute care hospitals available in the state of New Jersey via the identification method of our internal Network 360 tool. The Network 360 tool identifies provider options from those who are contracted with commercial plans as well as other Medicaid MCOs who may be able to fulfill the deficiency. Our Network department makes outreach to those providers for possible contacting into the network. They report the outcomes of those outreach efforts and also identify the areas where no providers for a specific specialty exist based on the Network 360 search tool findings. The results of the outreach efforts are presented to the quarterly Provider Advisory Committee in the Network Deficiency report. In some cases, there are general specialties where the provider will treat a pediatric member. We will note in the Network Deficiency report that these providers treat pediatric members and report what the geoaccess percentage would be if the provider were counted towards the total for the deficient county.

- *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 will continue to work with obstetric providers to ensure adequate access to prenatal care and request that providers who do not meet the requirement standards submit a corrective action plan to be re-evaluated. The plan will also conduct outreach to the non-compliant specialist providers to better understand their reasons for the 24 hour emergency appointment deficiency. Lastly, the plan will provide education to non-compliant specialist providers to ensure awareness of the 24 hour emergency appointment standard

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

UCS reviewed the auditors findings and found incorrect membership codes were captured in the 2018 NJ FIDE SNP and MLTSS universe. To remediate the issue, the NJ Health Plan provided guidance regarding the NJ population to ensure the appropriate membership is pulled into the universe.

This includes providing a listing of all NJ Plan Codes effective during the applicable review period. The plan codes applicable to the specific audit request are identified and then “bumped” up against the medical universe to identify the membership that is to be included in the audit. If there are any plan codes captured that are not in scope for the audit, UCS Regulatory Adherence removes out of scope plan codes from the universe.

Prior to submitting the universe, operational validation is completed which includes reviewing the plan codes to ensure the proper membership is included.

- *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.*

A Metric Checklist Form was developed to be completed at the time of the provider’s recredentialing cycle. The document will be added to the applicable provider’s file and made available for review upon request. This new process was added to the current Credentialing and Recredentialing Policy on November 14, 2019, was approved by the health plan’s Policy Committee on November 14, 2019 and the PAC Committee on November 20, 2019 and will be submitted to the State for approval.

- *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.*

To ensure that MLTSS credentialing and recredentialing is being tracked and monitored accurately, the MCO transitioned these services to the National Credentialing Center (NCC), December 2017. The NCC utilizes a database system that retains and monitors the credentialing and recredentialing cycles and files for all MLTSS providers. This database ensures that the providers are recredentialed within three (3) years.

Revisions regarding the overall licenses/certifications process have been made to the attached Initial and Recredentialing Process Job Aids and were disseminated to the staff on 2/26/19 showing best practice to use to confirm and document that contracted MLTSS providers are licensed to provide services in New Jersey. Ongoing monitoring by Supervisor and/or SME is performed weekly to further remediate this recommendation.

- *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.*

In the case of an enrollee currently receiving inpatient hospital service or emergency room care, UCS will make the determination involving continued or extended health care services within 24 hours, if all necessary clinical information needed to review is received.

If clinical is not received, clinical is requested and then once all necessary clinical information is received, UCS will make the determination involving continued or extended health care services within 24 hours.

The blended census reporting tool (BCRT) is a tool that the ICM team uses daily which captures examples of IP cases reviewed on a concurrent basis. The blended census reporting tool (BCRT) submitted for the audit to show compliance to the 24 hour turnaround time include two additional columns for clinical requested and clinical received data. The two additional columns will help explain the steps taken to review and meet turnaround time compliance.
Prior to submitting the blended census report to audit as supporting documentation, the Health Plan will review for accuracy.

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

The utilization management program established a methodology for tracking prior authorization cases which include Case ID, Plan, Requested Date, Decision Date, and the Decision Written/ Communicate Date.
Prior authorizations decisions and written notifications are tracked and retained by the prior authorization system, ICUE and can be reported on.

PDN Response: The plan utilizes the authorization detail report to monitor and track determinations of prior authorizations. This report is monitored by the PDN manager and Asst Director on a daily basis. The plan has also developed a PDN tracker to ensure cases are addressed timely by the case managers.

- *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.*

Grievance data is tracked in the Escalation Tracking System. The grievance case entry process requires that upon case entry, the member's line of business which identifies MLTSS or Non-MLTSS membership is populated. We are able to produce reports and universes based off of the line of business field to accurately separate universes for the MLTSS population from the Non-MLTSS population. Our Standard Operating Procedure for grievances has specific direction related to MLTSS member grievances which ensures that information regarding the member's grievance receipt and

outcome is shared with the member's case manager. In addition, we have recently requested state approval to enhance the grievance resolution process and letters to ensure that we are able to fully resolve and effectively communicate resolution regarding the members concern. These enhancements would include an outbound call to the member to explain the grievance process, gather additional information the member would like to provide and assist with locating a new provider upon the member's request. An overview of the conversation and any provider changes made will be added to the resolution letter that is sent to the member.

- *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.*

Appeal data is tracked in the Escalation Tracking System and the appeal case entry process requires that a prior authorization identification number, if applicable to the appeal, is documented within the system upon case entry. Prior Authorization data is located within a separate system called ICUE and all appeal review notes and determinations are documented within ICUE along with the Escalation Tracking System allowing for complete and accurate reporting of the UM process and 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 Authorization Detail and Universe Report is utilized to track and monitor enrollees who are receiving private duty nursing services and the status of these enrollees. The Authorization Detail Report provides information on pended, approved and denied services and is actively monitored by the PDN Manager to track and monitor the status of all Core and MLTSS PDN services.

- *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*

United Healthcare Community Plan prepared a <50th Percentile Work plan to address results for Medicaid measures from HEDIS 2018. The following measures fell below the 50th percentile per HEDIS 2018 Quality Compass results. We have listed a brief description of interventions implemented to improve each measure.

1. Developmental Screening In The First Three Years Of Life
    a. PC visits to providers to review HEDIS quality scores, provide codes, provide list of non-compliant members
    b. Reminder letters for EPSDT mailed annually as well as reminder calls
2. Adult BMI (ABA):
    a. CPC visits to providers to review HEDIS quality scores and provide list of noncompliant members with gaps in care
    b. Provide practices with measure code and definition and encourage documentation of BMI at sick visit
    c. Advise provider to use EMR template/activate or default setting
3. Avoidance Of Antibiotic Treatment In Adults With Acute Bronchitis (AAB):
    a. CPC visits to providers to educate provider/office staff regarding the measure definition and required codes
    b. PCP incentive program
4. Childhood Immunizations (CIS):
    a. Provider Profile mailing list of non-compliant members to target for outreach/member education via newsletter
    b. CPC visits to providers furnishing education related to vaccine schedule and coding
    c. PCPi provider incentive program
    d. Live outreach calls to members
    e. CPC visits with 13 FQHCs to review performance, discuss barriers, and review coding of immunizations
5. Weight Assessment And Counseling For Nutrition And Physical Activity For Children BMI percentile (WCC)
    a. Quarterly Provider Profile list of non-compliant members for follow up

b. CPC visits to providers to review HEDIS score review and educate on measure definition and coding
c. PCPi incentive program

6. Immunizations For Adolescents-Combo 2 (IMA):
   a. Quarterly Provider Profile list of non-compliant members for follow up
   b. CPC visits to providers to review HEDIS score review and educate on measure definition and coding
   c. PCPi provider incentive program
7. Follow-up Care For Children Prescribed ADHD Medication-Initiation (ADD) Initial Phase/Continuation And Maintenance Phase
   a. CPC visits to providers to review HEDIS quality scores, provide list of non-compliant members and provide measure definition and HEDIS codes
   b. Provider incentive program
   c. CPC/Behavioral Health Team provide education and encourage providers to limit the first prescription to a 14-21 day supply to ensure follow up visit compliance
   d. Educate provider focus on informing the parent of the importance of follow up within 2-3 weeks to ensure the medication is working and address any concerns/9 month follow up
8. Controlling High Blood Pressure/Comprehensive Diabetes Care (CBP) (CDC):
   a. CPC visits to providers to provide non-compliant members list and educate on measure definition and HEDIS codes
   b. Implementation of Diabetic Clinic Days
9. Asthma Medication Ratio (AMR) –Total
   a. Member notification of 90 day refill program
   b. CPC visits to provide practices education on Gaps In Care Asthma Program/education on 90 day refill program
   c. Provide member educational materials
   d. Provide practices with member educational materials

- *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 PIPs that were submitted for this recommendation period are as follows:

1. The final Preterm Birth PIP was submitted in July of 2018 and received a score of 95.
2. The Fall MLTSS Falls PIP was submitted in August 2019 and we have not received that score yet.
3. The Early Intervention PIP was submitted in August 2019 and received a score of 90.6.
4. The Adolescent Screening PIP was submitted in August of 2019 and received a score of 75 not meeting the 85 passing score due to some documentation miscommunication and not analytical data or Process measure issues.
5. The MLTSS GAP In Care PIP was submitted in August of 2019 and we have not received that score yet.

We had reviewed the auditors' recommendations and requests for clarification for the PIPs prior to the August submission. All recommendations were implemented to address the Auditors' concerns/corrections. The PIPs were then updated to include any process measures interventions results and also to evaluate the results and value of those interventions. Additional process measures and interventions were then added after review of any improvements in the process measures and/or the performance indicators. All PIPs were submitted in April and August of 2019.

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

1. Senior Clinical Analysts update the PIPs with any necessary information for the appropriate required submission.
2. The Quality Manager reviews in collaboration with the Senior Clinical Analysts for any incorrect or missing information and is corrected.
3. The Quality Director reviews the document for any corrections and recommendations. The PIPs are then revised as needed.

4. The PIPs are sent to the national Quality team for review and recommendations. Those corrections and/or recommendations are then incorporated into the documents before final submission.

Meetings and trainings are held quarterly to ensure that any process measures in place that requires the staff to complete tasks. They are as follows:
1. MLTSS Falls: Trainings were held quarterly and any results from the process measures were monitored. If results were not satisfactory then additional trainings and/or meetings with the Care Managers were implemented. We met the performance indicator at the time of the August 2019 final submission
2. Early Intervention: Meetings are held monthly with the member outreach staff and the Lead Case Managers to ensure that communication between these two groups is optimum and data is being tracked.
3. Adolescent screening: Continuous contact with the 3 specific practices occurs quarterly along with a mini audit to determine if progress is being made regarding the screenings. We did meet with IPRO to clarify several issues regarding interpretation of the process measures and implemented the changes for August 2019 submission
4. MLTSS GAPs in Care: Continuous monitoring of both the flu/pneumonia rates and the PCA services were implemented 3rd quarter of 2019. The documentation form for Care Managers was reviewed and changes to enhance the improved documentation by the Care Managers were implemented in the 3rd quarter of 2019.

We will continue to strive to improve this PIP and ensure that the PIP is clear and all document information is relevant to the outcome of the Performance Indicator.

- *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.*

The plan should focus on age-appropriate immunizations for the child population enrolled in care management. The health plan addresses age appropriate immunizations within the plan of care and pediatric core assessments. The member/guardian is educated around the importance of being up to date with immunizations. The Care Manager documents this activity in the clinical documentation system, in addition to educational mailings around immunizations.

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 Health Plan utilizes the UTD (Universal Tracking Data Base), as well as confirmation inquiries/outreach activities to the Rutger Child health Staff and the NJIIS system.

Upon contact with PCP or DCP&P staff the health plan staff will document all outcomes in the clinical documentation data base system.

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. C&S DCP&P staff are entering activities on outreach to the caregiver and the state agencies, documenting outcomes in the health plan's clinical and UTD system. Education is being provided to members via the CM's in addition to mailed information to reinforce this education that has been provided. Preventative services are addressed in the POC and additional outreach attempts are noted in the clinical documentation system.

- *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).

Process revision in progress for Plan of Care creation, revision, and touchpoint follow up to demonstrate member-centric approach to documenting care preferences, and to ensure that all enrollee needs and preferences are acknowledged. A job aid has been created to reflect the process changes. Training on the revised process to front-line staff rolling out December 2019 / January 2020. This training will be re-evaluated in the first quarter 2020 Monitoring is captured through our existing audits.

Regarding Risk Management agreements: Currently, all risk management agreements are reviewed and approved by MLTSS managers, and reviewed on an individual basis with front-line staff. As this is a manual process today, automation will be implemented in 2020. The purpose is to streamline the documentation of initiation of the risk management agreement in the Plan of Care. This will be included in the new Plan of Care touchpoint education. This is also included in the MLTSS Program Evaluation for SFY 2019.

All Plans of care are currently shared with Primary Care Physicians to engage PCP with any revisions or modifications needed. Every revised/updated POC is sent to the PCP for feedback/recommended changes every 90 days or in the event of a change in condition. Process change is planned to include pro-active physician engagement directly by care manager that will include an "unable to reach MD" process to begin Q1 2020, Process oversight to be implemented by Q2 2020.

MLTSS Staff is educated on the creation of SMART goals on an on-going basis via monthly staff meetings and 1:1 touchpoints.

Outreach to providers for members receiving Skilled Nursing Care, Traumatic Brain Injury Treatment, or Behavioral Health services occurs throughout the Care Management process. Outreach is documented in the ICUE platform. Additionally, IDT meetings are conducted to ensure comprehensive care coordination for members. Monitoring of Interdisciplinary Team Meeting documentation began in Q3 2019—continued education/reinforcement to front-line staff to be emphasized Q1 2020 on an on-going basis.

- *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.*

Monitoring of documentation of nursing facility plan of care, MLTSS plan of care, and IDT meetings began in Q3 2019 to facilitate coaching and transparency for the MLTSS managers. MLTSS manager to continue to provide coaching and training, and reinforce documentation on these areas throughout 2020 and beyond.

WCHP

WCHP addressed IPRO's July 1, 2017 to June 30, 2018 QTR recommendations as follows:

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

As of Q4 2019, the plan has satisfied the requirement for access standards in Cumberland, Gloucester and Warren counties for Adult PCP. For Pediatric PCP both Atlantic and Warren counties also meet access standards.

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

WellCare monitors hospital adequacy through our Geo-Access Reports and Hospital Adequacy Reports in our monthly JOC meetings. We will continue to monitor the Hospital and Provider Access to ensure we meet Network Adequacy in all our active counties and ensure our members receive access to all benefits covered under the contract. We are currently finalizing contracts with Hackensack/ Meridian health System and Penn Medicine, University of Princeton Medical Center. Both systems will allow us to fill deficiencies in our network and provide adequate coverage for our members. We will also continue to do SCA's with any non-par hospitals that will help provide coverage for our members.

- *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 network requirement for MLTSS is two providers per county. We continue to monitor the network through GEO ACCESS reports, and monthly directory pull. In addition, at the suggestion of EQRO WellCare has started summary reports that we will review at six-monthly intervals. 2019 WellCare recruitment efforts continue, however there are specialty limitations in some of the counties, an example of this is ALR in Hudson and Hunterdon County where there is one facility per county, and therefore network deficiency will always exist. This is also the case for TBI and Adult Family Care. When there are not enough Medicaid providers in a specific area to provide adequate, timely access, or in certain cases when certain high-need providers are not willing to contract with us due to rates, unwillingness to serve Medicaid enrollees, or for other reasons, we offer the option of Single Case Agreements. Where possible WellCare will continue outreach and engage providers to closed network gaps.

Assisted Living Services- Statewide providers -230. In network providers with WellCare 200. True State deficiency in Hudson and Hunterdon County, with one provider in each county.

ADULT FAMILY CARE- True State deficiency- There are 5 providers throughout the state supplying this service, 4 in Essex County and 1 in Camden County. WellCare has contracted the providers, as shown below:

1. CARE MANAGEMENT 2000 INC (Essex County) provider ID# 1193575,
2. ROYAL HOME CARE MANAGEMENT LLC, (Essex County) provider ID# 1001465 and
3. SENIOR CITIZENS UNITED COMMUNITY SERVICE provider ID#981588- (Camden County).

Where needed, WellCare will use its existing contracted providers in adjacent counties and will use Single Case Agreements, as needed, to provide this service.

Providers of Traumatic Brain Injury services- True State deficiency - There are 6 providers with TBI designation in the state. The providers deliver a range of services/specialties. WellCare has contracts with the 6 providers, in addition WellCare has a contract with Kessler where they provide rehab services to TBI members. WellCare also reached out to Bancroft Neuro Health and confirmed with Gina that the provider has the ability to service all Southern New Jersey, and Alexa at Universal Institute Inc. confirmed that they are able to service state wide.

Adult Medical Day Care- There are 147 Adult Medical Day Care facilities in the state. WellCare has contracts with 138 facilities in the state. One available provider per county in Cape May, Hunterdon, Sussex, and Warren County; WellCare has contracts with available providers.

PERS- (personal emergency response system) statewide providers- WellCare has 7 providers in network for this service.

Medication Dispensing Devices-statewide providers- WellCare has contracts with 2 providers.

Home Delivered Meals- statewide providers-WellCare has contracts with 2 providers.

COMMUNITY TRANSITION SERVICES - WellCare has two Representatives in house to assist with community transition services. Yvette Bosque and Lissette Verde. As supplemental coverage we also partner with some of the agencies to assist as needed.

Recruitment efforts continue, network remains open to providers requesting contracts and or available for contracting.

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

In 2019 the market created educational material specific to OB/GYN to reinforce our access standards on the expected standards for Access and Availability as it relates to their specialty. 100% of OB/GYN's not meeting Access and Availability requirements were outreached by the Provider Relations team. The results for passing requirements for first, second, third trimester and high risk appointment availability improved in all areas. On 8/1 /2019 WellCare began utilizing a new vendor (Faneuil) to help improve provider participation. Provider engagement under the new vendor has increased. See below:

First trimester care	Last Audit 80.4%	Current Audit 81.6 %
Second trimester care	Last Audit 82.6%	Current Audit 92.1%
Third trimester care	Last Audit 54.3%	Current Audit 78.9 %
High risk	Last Audit 52.2%	Current Audit 81. 6%

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

WCHP conducts quality focused provider education visits to all provider that do not meet NCQA 50th percentile benchmarks. This visits consist of education regarding coding and claims submission, and leaving behind provider Toolkit that lists all HEDIS measures and their medical record documentation requirements. Provider Relations and Quality have partnered to coordinate efforts to close care gaps and educate providers on clinical practice guidelines. This interdepartmental (POD) team approach reviews and identifies specific practices/providers who have opportunities for improvement of their HEDIS rate, missed opportunities, and they deliver care gap reports indicating which members require screening. The POD team also educates on proper coding, this process includes reviewing a sample of medical records to identify coding deficiencies then educating providers utilizing a laminated coding sheet with appropriate codes for billing purposes. WCHP leadership and Quality staff monitor on a monthly basis POD (Interdisciplinary) progress.

- *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.*

WHCP reviews and addresses PIP deficiencies as identified by IPRO. WCHP hired a full-time Sr. QI Project Manager dedicated to PIP coordination and oversight. In addition, a QI Data Analyst is utilized by assisting with analysis for each PIP. Monthly project meetings have been set up for each PIP to insure key elements (interventions) are implemented in timely manner and analyzed on an ongoing basis (at least on a quarterly basis). A QI Data Analyst routinely attends these monthly meetings. Key QI and Care Management staff attended IPRO's Annual PIP training for new and/or continued PIP education. Based on IPRO scores of WCHP's PIP submissions in August 2019, the Plan has demonstrated improvement in all four PIPs and exceeded an overall score of 85% (MET) as follows: MLTSS Gaps in Care (87.5%), Adolescent High Risk Behaviors and Depression (87.5%), and MLTSS Falls Prevention PIP (92.5%). One PIP, Early Intervention to Prevent Developmental Delays achieved 100%.

- *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.

WCHP focuses on age- appropriate immunizations for the child and adults populations enrolled in CM including lead testing. Lead testing is monitored on all members 0-72 months old. Members identified with a BLL level of 5 or greater are referred to care management. Members identified with a BLL of 4 will receive a Lead Verbal Risk Assessment, any answer of YES will be sent to the Care Manager for outreach. A goal is created for all members identified that have not received a BLL. Care managers frequently outreach the parent/guardian, PCP, or DCPP nurse in attempts to get the member tested. Care Managers are expected to outreach and educate parents and/or guardians on lead testing. Care Management notes are updated frequently and audited. Early and periodic screening, diagnostic and treatment services (EPSDT) for pediatric members between the ages of 0-21 are obtainable, this includes immunization review and management for age specific immunizations including lead. Care Management offers assistance with appointment scheduling and will provide follow-up with missed appointments and referrals identified with completed EPSDT exams. On a quarterly basis, PCPs receive a list of enrollees whom have not had an encounter or whom have not complied with EPSDT periodicity.

- *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.*

To 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), the following was put in place:
1. Plans of care are reviewed and discussed in 1:1 case conferences between MLTSS managers and care managers and tracked via quarterly CM audits to ensure that Plans of Care are developed using “person-centered principles”.
2. MLTSS Management team requires newly hired care managers to submit 100% of care plans for review at time of completion until their Manager/Supervisor is satisfied with plan of care quality, including that Plans of Care are developed using “person-centered principles”.
3. Two MLTSS members are discussed at each individual care management team's regular staff meeting, which includes discussing the quality of the plan of care to reinforce best practices in plan of care completion.
4. Care Plans are being reviewed and tracked by a team scorecard that focuses on Plans of Care being developed using person-centered principles. One Clinical Quality Manager has taken the lead on this initiative and Care Managers that have Plans of Care not meeting these standards will be re-educated as needed.
5. New verbiage was added to the standardized note templates to include:
---Cultural and linguistic needs and preferences
---P.A.C.E option offered

To ensure risk management agreements are signed and included with all components when there is positive indication of risk:
1. Once a Risk Management Agreement is completed and signed by the member/member representative, the Care Manager notifies the MLTSS Team Manager. The Manager's review and signature is required in order to close the Risk Management Agreement in WellCare’s electronic care management information system.
2. WellCare's standardized visit note templates for initial and subsequent face-to-face visits are used to ensure that required documentation is completed for member visits.
3. The standardized visit note template was revised to add areas where the care manager needs to indicate:
--- whether a Risk Assessment was done
--- a risk was identified

--- if a Risk Management Agreement was completed.
4. All active Risk Management Agreements are reviewed in 1:1 case conferences between the MLTSS Manager and Care Manager to ensure the Risk Management Agreement is signed and all components addressed.
5. Risk Management Agreements are tracked via quarterly CM Audits

- *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.*

To 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:
1. Staff was re-educated of this requirement at team meetings.
2. Ongoing feedback provided to correct behavior and drive to 90% compliance at minimum.
3. MLTSS Manager monitors compliance with this requirement via the following methods:
-1:1 case conferences between manager and care manager
-Monthly CM audits
-Monthly facility scorecard
4. A nursing facility team specific scorecard was implemented to target the requirements for this population including presence of the date facility plan of care was received as well as documentation that the CM reviewed the facility Plan of Care (POC) and documented it in the care management record.
Management will use these findings to address individual care manager and team performance driving towards 90% timeliness compliance at minimum.
5. A specific facility visit note template has been created and in use by care management staff. The template addresses care manager's review of the facility POC.

To ensure participation in facility IDT meetings:
1. A facility team specific scorecard was implemented to focus on the requirements for this population including evidence of attendance at the annual IDT within the care management record.
2. Care Managers complete the scorecard weekly for each new member assigned to them to indicate timeliness for facility member specific measures. Scorecard information is 100% verified by the nursing facility Supervisor/Manager and submits the completed team scorecard monthly to a shared drive for MLTSS Director to review and report findings to the VP of Health Services.
3. A facility specific facility visit note template has been created and is currently in use which captures this requirement.
4. The MLTSS manager uses the monthly CM audits to verify annual IDT attendance for each custodial member.
5. The MLTSS manager will verify that an IDT is scheduled annually and monitors attendance during 1:1 case conferences via the Care Manager's 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.
6. At the initial and subsequent face to face visits, the care manager speaks with staff about dates of upcoming IDTs and necessity of care manager presence/involvement and documents in member's care management record.
7. A Quick Reference Guide (QRG) is placed on each of WellCare's MLTSS member's chart at the facility. This QRG includes care manager's name, contact information and a section on "when to contact the care manager" in which the IDT is listed.
8. MLTSS CM to re-educate facility staff on importance of contacting care manager with any changes in IDT date. Care Manager to call facility day before scheduled IDT to confirm.

To ensure timely onsite review for member placement and services:
1. Timeliness of subsequent facility face-to-face visits are tracked in WellCare's quarterly care management audits.
2. WellCare produces a weekly Case Note Report that is distributed to MLTSS Care Management Managers for use in tracking care management activity by note type to help ensure member face-to-face visits are conducted in a timely manner.
3. WellCare's MLTSS care managers were re-educated on the requirement that subsequent face-to-face visits need to be done at least every 180 days for nursing facility members. Care Managers to plan visits every 160-179 days to ensure

compliance and document if the member or member representative is not available during that timeframe or cancels a scheduled visit.
4. Timeliness of member face-to-face visits is reviewed and discussed during 1:1 case conferences between care managers and their managers. Findings from these conferences are used to address individual care manager performance.

CHAPTER 5 – CONCLUSIONS AND RECOMMENDATIONS

This report has provided an overview of activities and findings for January 2019–December 2019. The following section provides a summary of MCO-specific strengths and opportunities for improvement.

ABHNJ

ABHNJ had an enrollment of 65,643 for Core Medicaid and MLTSS as of December 2019, which represented 4% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

ABHNJ's compliance score for 7 of 14 reviewed standards in the 2019 Annual Assessment of Operations Review was 100%.

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

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Comprehensive Diabetes Care (CDC; Medical Attention for Nephropathy); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; BMI percentile - 3-11 Years, Counseling for Nutrition - 3-11 Years, Counseling for Nutrition - 12-17 Years, Counseling for Nutrition – Total, Counseling for Physical Activity - 3-11 Years, Counseling for Physical Activity - 12-17 Years, Counseling for Physical Activity – Total); and Use of Opioids From Multiple Providers (UOP; Multiple Prescribers and Multiple Prescribers and Multiple Pharmacies).

In the 2019 Core Medicaid CM audit, ABHNJ scored above the 80% standard for one category (Coordination of Services) for all three populations (General, DDD, and DCP&P). ABHNJ scored 100% for Identification for the DCP&P and DDD populations, and scored 100% for Outreach and Coordination of Services for the DDD population. The plan scored at or above 91% for all categories (Identification, Outreach, Preventive Service, Continuity of Care, and Coordination of Services) for the DCP&P population.

In the 2019 MLTSS HCBS CM audit, ABHNJ scored above 90% for MLTSS PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment).

In the 2019 MLTSS NF CM audit, ABHNJ scored at or above 90% for MLTSS Plan of Care on File, Written Member Goals include all 5 Components, Plan of Care addresses formal and informal services, Plan of Care developed with person-centered principles, Member and/or representative participated in the development of goals, Member was identified for transfer to HCBS, Member was present at each onsite visit, Coordination of care, New Jersey Choice Assessment completed, NJCA completed for Members newly enrolled in managed care, NJCA completed for Members enrolled in MLTSS with the MCO, Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF, and Communication of PASRR Level II.

Opportunities for Improvement

ABHNJ scored below 85% compliance in 3 of the 14 standards in the 2019 Annual Assessment of Operations Review. ABHNJ scored 71% for Access, 82% for Provider Training and Performance, and 80% for Efforts to Reduce Healthcare Disparities, 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.

In the 2019 Core Medicaid CM audit, the plan scored below the 80% standard and has opportunities for improvement in the following elements: Identification (General Population; 62%), Outreach (General Population; 74%), Preventive Services (General Population; 51%), Continuity of Care (General Population; 69%), and Preventive Services (DDD; 76%).

Based on the 2019 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), PM#11 (Plans of care developed using "person-centered principles"), PM#12 (MLTSS HCBS plans of care that contain a back-up plan), and PM#16 (Member training on identifying/reporting critical incidents).

Based on the 2019 MLTSS NF audit the plan scored below the 85% standard and has opportunities for improvement in the following elements: Copies of any Facility Plans of Care on file (77%), Documented Review of the Facility Plan of Care (67%), Completion of Initial Plan of Care (9%), Agreement/Disagreement statements from the Plan(s) of Care (59%), Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (12%), Timely Onsite Review of Member Placement and Services (21%), Updated Plan of Care for a Significant Change (17%), and Communication of PASRR Level I (83%).

Recommendations

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

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

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

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

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

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

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

For the Core Medicaid CM Audit, recommendations for the General Population and DDD Population include the following:

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

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

Recommendations for Assessment category include:

- Group D: The New Jersey Choice Assessment should be completed within 30 days of the referral, and should be submitted to OCCO within five (5) business days of the assessment date.
- Group E: The MCO should include the date of the last authorized NJCA by OCCO, and the MCO should ensure a NJCA is completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.

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

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

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

- Groups C and D: The MCO should ensure an initial POC and back-up-plan is completed, signed and provided to the member/authorized representative within 45 calendar days of enrollment in MLTSS.
- Group E: The MCO should ensure an annual POC and back-up-plan is reviewed and signed within 30 days of the member's anniversary from the date of the initial POC.

Recommendations for the Ongoing Care Management category include:

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

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

- The MCO should ensure the facility POC is on file, and the care manager's review of a facility plan of care is documented.
- The Initial MLTSS POC should be completed within 45 days of MLTSS enrollment and the care manger should certify the agreement/disagreement statement is reviewed and signed by the member/POA.
- ABHNJ should confirm there is documentation of participation in facility IDT meetings, and the onsite review of member's placement and services is timely, and there is documentation of an updated POC for a significant change.
- ABHNJ should ensure there is sufficient communication of PASRR Level I, as applicable prior to a NF/SCNF transfer.

AGNJ

AGNJ had an enrollment of 187,882 for Core Medicaid and MLTSS as of December 2019, which represented 12% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

AGNJ's compliance score for 10 of 14 reviewed standards in the 2019 Annual Assessment of Operations Review was 100%.

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

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Adolescent Well-Care Visits (AWC); Comprehensive Diabetes Care (CDC; HbA1c Poor Control [>9.0], HbA1c Control [<8.0], and HbA1c Control [<7.0] for a Selected Population); Prenatal and Postpartum Care (PPC; Timeliness of Prenatal Care); Immunizations for Adolescents (IMA; Meningococcal; Tdap/Td; and Combination 1); Appropriate Testing for Children with Pharyngitis (CWP); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC; 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; 25 Months - 6 Years and 7-11 Years); Follow-up After Emergency Department Visit for Mental Illness (FUM; 6-17 years – 30-Day Follow-up, 18-64 years - 30-Day Follow-up, 18-64 years - 7-Day Follow-up, 30-Day Follow-up and 7-Day Follow-up); Use of Opioids From Multiple Providers (UOP; Multiple Pharmacies and Multiple Prescribers and Multiple Pharmacies); and Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC; 6-11 Years).

In the 2019 Core Medicaid CM audit, AGNJ scored at or 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 for the DDD and DCP&P population. The MCO also scored 100% in Preventive Services for the General Population, and Outreach, Continuity of Care and Coordination of Services for the DDD Population.

In the 2019 MLTSS HCBS CM audit, AGNJ scored above 90% for MLTSS PM#8 (Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS), PM#9 (Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary), PM#9a (Member's Plan of Care is amended based on change of member condition), PM #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment), PM#11 (Plans of Care developed using "person-centered principles"), and PM#16 (Member training on identifying/ reporting critical incidents).

In the 2019 MLTSS NF CM audit, AGNJ scored at or above 90% for MLTSS Plan of Care on File, Completion of Initial Plan of Care, Agreement/Disagreement statements from the Plan(s) of Care, Written Member Goals include all 5 Components, Plan of Care addresses formal and informal services, Plan of Care developed with person-centered principles, Member and/or representative participated in the development of goals, Member was identified for transfer to HCBS, Member was present at each onsite visit, Coordination of care, Updated Plan of Care for a Significant Change, New Jersey Choice Assessment completed, NJCA completed for Members enrolled in MLTSS with the MCO, and Training on how to report a critical incident.

Opportunities for Improvement

AGNJ received a compliance score of 64% for Access in the 2019 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. Review of the Core Medicaid/MLTSS PIPs identified opportunities to implement interventions on a timely basis as the plan struggled to identify appropriate start dates. The plan should review ITMs; the plan is tracking interventions predominantly in terms of the provider count. This is insufficient and the Plan should review how interventions are being tracked, and develop more meaningful tracking measures.

Based on the 2019 MLTSS HCBS CM audit, AGNJ has opportunities for improvement in the following MLTSS PM#12 (MLTSS HCBS plans of care that contain a back-up plan).

Based on the 2019 MLTSS NF audit the plan scored below the 85% standard and has opportunities for improvement in the following elements: Copies of any Facility Plans of Care on file (78%), Documented Review of the Facility Plan of Care (78%), Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (33%), Timely Onsite Review of Member Placement and Services (48%), NJCA completed for Members newly enrolled in managed care (84%), Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF (63%), Communication of PASRR Level I (50%), Communication of PASRR Level II (50%), and Specialized Services Setting was coordinated appropriately with DDD/DMAHS (50%).

Recommendations

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

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

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

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

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

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

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

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

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

Recommendations for the Member Outreach category include:

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

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

- Groups C and D: The MCO should ensure the Member has a completed and signed interim POC. The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option.
- Group E: The MCO should ensure the Member has a completed and revised POC. The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option.
- Groups C, D and E: The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.
- The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

Recommendations for the Ongoing Care Management category include:

- Groups C, D and E: The MCO should ensure the Member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes.
  Group E: The MCO should ensure the Member has a completed and revised POC. The MCO should ensure members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan had their Back-up Plan reviewed with the member at least on a quarterly basis.

Recommendations for the 2019 MLTSS NF audit include the following:

- The MCO should ensure the facility POC is on file, and the care manager's review of a facility POC is documented.
- The MLTSS care manager should confirm there is documentation of participation in facility IDT meetings, the NJCA should be completed annually for members newly enrolled in managed care, and ensure the onsite review of member's placement and services is timely.
- AGNJ should ensure the Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF.
- AGNJ should ensure that there is sufficient communication of PASRR Level I and Level II, and that there is sufficient coordination with DDD/DMAHS for specialized services setting.

HNJH

HNJH had an enrollment of 841,457 for Core Medicaid and MLTSS as of December 2019, which represented 53% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

HNJH's compliance score for 10 of 14 reviewed standards in the 2019 Annual Assessment of Operations Review was 100%.

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

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Immunizations for Adolescents (IMA; Meningococcal, Tdap/Td, Combination 1);Follow-up After Emergency Department Visit for Mental Illness (FUM; 6-17 years - 7-Day Follow-up; 18-64 years – 30-Day Follow-up; 18-64 years 7-Day Follow-up; 30-Day Follow-up; 7-Day Follow-up); Children and Adolescents' Access to Primary Care Practitioners (CAP; 25 Months - 6 Years; 7-11 Years; 12-19 Years); Annual Dental Visit (ADV; 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 should have ITMs that have numerators and denominators that match the stated interventions they are tracking and ensure long and short term goals are completed properly.

In the 2019 Core Medicaid CM audit, HNJH scored above the 80% standard for all five categories (Identification, Outreach, Preventive Service, Continuity of Care, and Coordination of Services) for the DDD and DCP&P populations. HNJH also scored 100% in Identification for the DDD and DCP&P population. The plan also scored 100% in the Outreach, Continuity of Care, and Coordination of Services categories for the DCP&P Population.

In the 2019 MLTSS HCBS CM audit, HNJH scored 100% for MLTSS 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), 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 2019 MLTSS NF CM audit, HNJH scored at or above 90% for MLTSS Plan of Care on File, Completion of Initial Plan of Care, Agreement/Disagreement statements from the Plan(s) of Care, Written Member Goals include all 5 Components, Plan of Care addresses formal and informal services, Plan of Care developed with person-centered principles, Member and/or representative participated in the development of goals, Member was identified for transfer to HCBS, Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting, Member was present at each onsite visit, Coordination of care, Care Manager explained and discussed any payment liability, Updated Plan of Care for a Significant Change, New Jersey Choice Assessment completed, NJCA completed for Members newly enrolled in managed care, NJCA completed for Members enrolled in MLTSS with the MCO, Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF, Communication of PASRR Level I, Communication of PASRR Level II, and Specialized Services Setting was coordinated appropriately with DDD/DMAHS.

Opportunities for Improvement

HNJH received a compliance score of 79% for Access in the 2019 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 2019 Core Medicaid CM audit, the plan scored below the 80% standard and has opportunities for improvement in the following elements; Identification (General Population; 70%), Outreach (General Population; 57%), and Preventive Services (General Population; 76%).

Based on the 2019 MLTSS HCBS CM audit, HNJH has opportunities for improvement in the following MLTSS PM#11 (Plans of care developed using "person-centered principles).

Based on the 2019 MLTSS NF audit the plan scored below the 85% standard and has opportunities for improvement in the following elements: Copies of any Facility Plans of Care on file (79%), Documented Review of the Facility Plan of Care (79%), Timely Onsite Review of Member Placement and Services (68%), and Training on how to report a critical incident (82%).

Recommendations

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

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

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

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

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

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

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

- HNJH should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled members. HNJH should also utilize ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members demonstrating potential care management needs.
- HNJH should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources. Outreach attempts should include various types of methods, such as telephonic, written correspondence, provider contact, external agency contact, home visits, etc. HNJH should continue to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.
- HNJH should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of EPSDT exams for the child population. HNJH should ensure that dental needs for the child and adult are addressed for all members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of preventative and dental services and to educate members of the need/benefit of such services.

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

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

- Groups C and D: The MCO should ensure the Care, and the member received option counselling, incorporating a discussion of the participant direction program. The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT.

Recommendations for the Ongoing Care Management category include:

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

Recommendations for the 2019 MLTSS NF audit include the following:

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

UHCCP

UHCCP reported an enrollment of 418,378 for Core Medicaid and MLTSS as of December 2019, which accounts for 26% of the State's Medicaid and MLTSS managed care enrollment.

Strengths

UHCCP's compliance score for 5 of 14 reviewed standards in the 2019 Annual Assessment of Operations Review was 100%.

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

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Comprehensive Diabetes Care (CDC; HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population); Immunizations for Adolescents (IMA; Meningococcal, Tdap/Td, Combination 1); Appropriate testing for children with pharyngitis (CWP); Follow-up After Emergency Department Visit for Mental Illness (FUM; 18-64 years - 7-Day Follow-up, 7-Day Follow-up); Annual Monitoring for Patients on Persistent Medications (MPM; ACE Inhibitors or ARBs, Diuretics, Total); Children and Adolescents' Access to Primary Care Practitioners (CAP; 12-24 Months, 25 Months - 6 Years, 7-11 Years, 12-19 Years); Adults' Access to Preventive/Ambulatory Health Services (AAP; 65+ Years); Annual Dental Visit (ADV; 2-3 Years, 4-6 Years, 7-10 Years, 11-14 Years, 15-18 Years, 19-20 Years, Total); Adults' Access to Preventive/Ambulatory Health Services (AAP; 65+ Years); Use of Opioids From Multiple Providers (UOP; Multiple Prescribers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies); and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM; 12-17 Years).

In the 2019 Core Medicaid CM audit, UHCCP scored above the 80% standard for all five categories for the DDD and DCP&P populations, and for the Coordination of Services category for the General Population. The plan scored 100% in Identification, Preventive Services, and Coordination of Services for the DDD Population, and 100% in the Identification and Coordination of Services categories for the DCP&P population.

In the 2019 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 2019 MLTSS NF CM audit, UHCCP scored at or above 90% for MLTSS Plan of Care on File, Member was identified for transfer to HCBS, Member was present at each onsite visit, NJCA completed for Members newly enrolled in managed care, Specialized Services Setting was coordinated appropriately with DDD/DMAHS, NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF, Plan of Care Updated Prior to Discharge from a Facility, Person-centered transition Plan of Care on file, Participation in an IDT related to Transition, Authorizations and procurement of transitional services, and Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.

Opportunities for Improvement

UHCCP received a compliance score of 71% for Access, 78% for Quality Management, 80% for Efforts to Reduce Healthcare Disparities, and 79% for Utilization Management in the 2019 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. The plan should ensure Performance Indicators are clearly defined and should ensure interventions are measurable.

In the 2019 Core Medicaid CM audit, the plan scored 80% and has opportunities for improvement in the following elements; Identification (General Population; 58%), Outreach (General Population; 57%), Preventive Services (General Population; 65%), and Continuity of Care (General Population; 64%).

Based on the 2019 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).

Based on the 2019 MLTSS NF audit the plan scored below the 85% standard and has opportunities for improvement in the following elements: Copies of any Facility Plans of Care on file (66%), Documented Review of the Facility Plan of Care (37%), Completion of Initial Plan of Care (19%), Agreement/Disagreement statements from the Plan(s) of Care (70%), Written Member Goals include all 5 Components (64%), Plan of Care addresses formal and informal services (83%), Plan of Care developed with person-centered principles, (72%), Member and/or representative participated in the development of goals (76%), Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (11%), Timely Onsite Review of Member Placement and Services (19%), Coordination of care (50%), Updated Plan of Care for a Significant Change (9%), Training on how to report a critical incident (63%), Communication of PASRR Level 1 (63%), and Communication of PASRR Level II (50%).

Recommendations

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

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

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

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

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

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

The plan 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 continue to utilize strong interventions and ITM's to ensure the plan is capturing meaningful data.

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

- UHCCP should continue to ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled members.
- UHCCP should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources. UHCCP should continue to ensure that aggressive outreach is used to complete a CNA when initial outreach is unsuccessful.
- UHCCP should continue to focus on age-appropriate immunizations for the adult populations enrolled in care management. UHCCP should ensure that dental needs are addressed for all children and adult members enrolled in care management, including documentation of the last visit date. UHCCP should ensure the member's CNA and POC are completed timely.

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

Recommendations for the Assessment category include:

- Group D: Although not scored, the MCO should complete a screening tool prior to completing a New Jersey Choice Assessment (NJCA) to identify potential MLTSS needs. The New Jersey Choice Assessment should be completed within 30 days of the referral.

Recommendations for the Member Outreach category include:

- Group D: The MCO should have a process in place to document the date/s of successful and unsuccessful outreaches to schedule a face-to-face visit for the purpose of creating a POC within five (5) business days from the effective date of MLTSS enrollment.

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

- Groups C, D and E: The MCO should ensure that participant direction application packages were submitted to DMAHS by the MCO within 10 business days of completion for members who select the option. The MCO should ensure that cost-effectiveness evaluations are completed and sufficiently documented and that the pre-call meeting and IDT meeting are requested or held within the appropriate timeframes for evaluations that exceed the documented ACT**.**

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

- Groups C and D: The MCO should ensure a completed and signed initial POC is provided to the member and/or member representative within 45 calendar days of enrollment into the MLTSS program.
- Group E: The MCO should ensure member's annual POC is reviewed within 30 days of the member's anniversary (from the date of the Initial POC).
- Groups C, D and E: The MCO should ensure there is documentation to reflect a member-centric approach, which demonstrates involvement of the member in the development and modification to the agreed-upon goals; this includes that the member and member representative, as applicable, are reflected in the documentation as present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that needs or preferences were acknowledged and addressed in the POC. The MCO should ensure

that there is documentation of a completed and signed state mandated Back-up Plan. The MCO should ensure that a signed Risk Management Agreement is documented when the Risk Assessment identifies a positive risk indicator.

Opportunities for improvement for elements of the Ongoing Care Management category include:

- Groups C, D and E: The MCO should ensure the member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes. The MCO should ensure there is documentation of a face-to-face visit by a Care Manager within ten business days of a documented date of discharge from an institutional facility to a HCBS setting. The MCO should ensure the POC is amended, based on a significant change in condition. The amended POC should be reviewed, signed and dated by the member and/ or authorized representative.

Recommendations for the 2019 MLTSS NF audit include the following:

- UHCCP should ensure the facility POC is on file, and the care manager's review of a facility POC is documented.
- Within 45 days of MLTSS enrollment the initial POC should be completed, agreement/disagreement statement is signed, and ensures documentation of written member goals which include all 5 components and confirm the care manager addresses formal and informal services.
- The MLTSS POC should be developed utilizing person-centered principles, and the member and/or representative is included in the development of goals.
- UHCCP should ensure that there is documentation of participation in facility IDT meetings, and the onsite review of member placement and services are timely including documentation of care coordination as applicable, member training on identifying/reporting critical incidents is documented, that there is documentation of an updated POC for a significant change.
- UHCCP should ensure that there is sufficient communication of PASRR Level I and Level II.

WCHP

WCHP reported an enrollment of 73,439 for Core Medicaid and MLTSS as of December 2019. This was 5% of New Jersey's Medicaid and MLTSS managed care enrollment.

Strengths

WCHP's compliance score for 12 of 14 reviewed standards in the 2019 Annual Assessment of Operations Review was 100%.

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

For HEDIS PMs, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34); Comprehensive Diabetes Care (CDC; HbA1c Control [<8.0%], HbA1c Control [<7.0%] for a Selected Population, Medical Attention for Nephropathy); Immunizations For Adolescents (IMA; Tdap/Td); Adult BMI Assessment (ABA); Follow-up After Emergency Department Visit for Mental Illness (FUM; 18-64 years - 30-Day Follow-up, 18-64 years - 7-Day Follow-up); Annual Monitoring for Patients on Persistent Medications (MPM; ACE Inhibitors or ARBs, Diuretics, Total); Children and Adolescents' Access to Primary Care Practitioners (CAP; 25 Months - 6 Years, 7-11 Years, 12-19 Years); Adults' Access to Preventive/Ambulatory Health Services (AAP; 65+ Years); Medication Management for People with Asthma (MMA; 75% Compliance rates for 19-50 Years, Total – 75% Compliance); Annual Dental Visit (ADV; 2-3 Years); Use of Opioids From Multiple Providers (UOP; Multiple Prescribers, Multiple Pharmacies, Multiple Prescribers and Multiple Pharmacies); and Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM; 12-17 Years, Total).

In the 2019 Core Medicaid CM audit, WCHP scored above the 80% standard for all categories (Identification, Outreach, Preventive Service, Continuity of Care, and Coordination of Services) for the all three populations. WCHP scored 100% for Preventive Services category for the General Population and 100% for Identification, Preventive Services, and Continuity of Care for the DDD population. The plan also scored 100% for the Identification, Outreach, and Continuity of Care categories for the DCP&P population.

In the 2019 MLTSS HCBS CM audit, WCHP scored above 90% for MLTSS PMs #8 (Initial Plan of Care established within 45 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"), #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 2019 MLTSS NF CM audit, WCHP scored at or above 90% for MLTSS Plan of Care on File**,** Member was present at each onsite visit, Care Manager explained and discussed any payment liability, Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF, and Communication of PASRR Level I.

Opportunities for Improvement

WCHP received a compliance score of 57% for Access in the 2019 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. The plan should continue to strengthen and address deficiencies in Performance Indicators and ensure there is data to support the AIM statement and Objectives.

Based on the 2019 MLTSS HCBS CM audit, WCHP has opportunities for improvement in the following MLTSS PM #9a (Member's plan of care is amended based on change of member condition.

Based on the 2019 MLTSS NF audit the plan scored below the 85% standard and has opportunities for improvement in the following elements: Completion of Initial Plan of Care (27%), Agreement/Disagreement statements from the Plan(s) of Care (30%), Written Member Goals include all 5 Components (32%), Plan of Care addresses formal and informal services (30%), Plan of Care developed with person-centered principles, (29%), Member and/or representative participated in the development of goals (29%), Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting (75%), Timely Onsite Review of Member Placement and Services (28%), Coordination of care (84%), Updated Plan of Care for a Significant Change (0%), New Jersey Choice Assessment completed (74%), NJCA completed for Members enrolled in MLTSS with the MCO (66%), and Training on how to report a critical incident (81%).

Recommendations

The plan should ensure that additional adult and pediatric PCPs and specialists 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 continue to expand the MLTSS network to include at least two providers in every county for assisted living and social day care. The plan should continue to negotiate contracts to meet deficient coverage areas for MLTSS specialty providers.

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

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 their Performance Indicators and Interventions to address deficiencies in implementation for all Core Medicaid and MLTSS PIPs that were active at the end of the review period.

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

Recommendations for the Assessment category include:

- Group E: The MCO should ensure documentation includes the date of the last authorized NJCA by OCCO (either the date of an approval letter or electronic approval). WellCare should ensure the NJCA is completed within 11 to 13 months from the previous NJCA to reassess for clinical eligibility.

Recommendations for the Member Outreach category include:

- Group C: The MCO should have a process in place to document the date/s of successful and unsuccessful outreaches to schedule a face-to-face visit for the purpose of developing a POC within five (5) business days from the effective date of MLTSS enrollment.

Recommendations for the Ongoing Care Management category include:

- Groups D and E: The MCO should ensure the member had a documented face-to-face visit to review member placement and services during the review period that was held within the appropriate quarterly or semi-annual timeframes. The MCO should ensure members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan had their Back-up Plan reviewed with the member at least on a quarterly basis.

Recommendations for the 2019 MLTSS NF audit include the following:

- WCHP should certify that within 45 days of MLTSS enrollment the initial POC should be completed, agreement/disagreement statement is signed, and ensure documentation of written member goals which include all 5 components and confirm the care manager addresses formal and informal services.
- The MLTSS POC should be developed utilizing person-centered principles, and ensure the member and/or representative is included in the development of goals.
- WCHP should ensure there is documentation of participation in facility IDT meetings, and the onsite review of member placement and services is timely including documentation of care coordination if applicable. Member training on identifying/reporting critical incidents should be documented.
- WCHP should ensure a NJCA is completed at least annually and there is documentation of an updated POC for a significant change in member's condition including the member's signature.

APPENDIX: January 2019–December 2019 MCO-Specific Review Findings

Appendix Table of Contents

ABHNJ 2019 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	14	9	14	10	4	0	71%	4	1	0
Quality Assessment and Performance Improvement	10	10	10	10	0	0	100%	0	0	0
Quality Management	18	17	18	16	2	0	89%	1	0	1
Efforts to Reduce Healthcare Disparities	5	2	5	4	1	0	80%	1	2	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	36	44	44	0	0	100%	0	7	0
Provider Training and Performance	11	11	11	9	2	0	82%	0	0	2
Satisfaction	4	4	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	41	40	41	39	2	0	95%	1	0	1
Credentialing and Recredentialing	10	9	10	9	1	0	90%	1	0	0
Utilization Management	30	29	30	26	4	0	87%	0	3	4
Administration and Operations	13	13	13	13	0	0	100%	0	0	0
Management Information Systems	18	17	18	17	0	1	100%	0	0	0
TOTAL	**235**	**214**	**235**	**218**	**16**	**1**	**93%**	**8**	**13**	**8**

[1] A total of 123 elements were reviewed in the previous review period; of these 123, 100 were *Met* and 2 were *N/A*. Remaining elements (114) that were *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

ABHNJ Performance Measures

ABHNJ HEDIS 2019 Restated Performance Measures

Aetna omitted the PCR and COU measures from HEDIS 2019 reporting. Aetna ran the measures after the 2019 HEDIS submission date. IPRO reviewed and validated these measures in October 2019. The rates are indicated below:

HEDIS 2019 Measure(s)	ABHNJ Rate	Status
Risk of Continued Opioid Use (COU) [1,2]		
18-64 years - >=15 Days covered	5.75%	R
18-64 years - >=31 Days covered	1.92%	R
65+ years - >=15 Days covered	15.79%	R
65+ years - >=31 Days covered	15.79%	R
Total - >=15 Days covered	5.93%	R
Total - >=31 Days covered	2.17%	R
Plan All-Cause Readmissions (PCR)[3]		
1-3 Index Stays per Year - 18-44	8.78%	R
1-3 Index Stays per Year - 45-54	10.20%	R
1-3 Index Stays per Year - 55-64	6.43%	R
1-3 Index Stays per Year - Total	8.56%	R
Observed-to-Expected Ratio	0.54	R
4+ Index Stays per Year - 18-44	53.85%	R
4+ Index Stays per Year - 45-54	53.13%	R
4+ Index Stays per Year - 55-64	58.49%	R
4+ Index Stays per Year - Total	56.12%	R
Observed-to-Expected Ratio	1.39	R
Total Index Stays per Year - 18-44	10.91%	R
Total Index Stays per Year - 45-54	17.88%	R
Total Index Stays per Year - 55-64	20.73%	R
Total Index Stays per Year - Total	15.77%	R
Observed-to-Expected Ratio	0.81	R

[1]Higher rates for COU indicates poorer performance.

[2]COU is a new measure this year.

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

ABHNJ Performance Improvement Projects

ABHNJ PIP 1: Reduction of Falls Among Home and Community-Based Members in MLTSS

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Reduction in Falls Among Home and Community-Based Members in MLTSS**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed				NM	M
1b. Impacts the maximum proportion of members that is feasible				M	PM
1c. Potential for meaningful impact on member health, functional status or satisfaction				M	PM
1d. Reflects high-volume or high risk-conditions				M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)				M	PM
Element 1 Overall Review Determination				PM	PM
Element 1 Overall Score				**50.0**	**50.0**
Element 1 Weighted Score				**2.5**	**2.5**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals				PM	PM
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark				PM	M
2c. Objectives align aim and goals with interventions				M	PM
Element 2 Overall Review Determination				PM	PM
Element 2 Overall Score				**50.0**	**50.0**
Element 2 Weighted Score				**2.5**	**2.5**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Reduction in Falls Among Home and Community-Based Members in MLTSS**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)				PM	PM
3b. Performance indicators are measured consistently over time				M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes				M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined				PM	PM
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]				PM	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.				N/A	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline				PM	M
3h. Study design specifies data analysis procedures with a corresponding timeline				PM	M
Element 3 Overall Review Determination				PM	PM
Element 3 Overall Score				**50.0**	**50.0**
Element 3 Weighted Score				**7.5**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics				N/A	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach				N/A	M
4c. Provider input at focus groups and/or Quality Meetings				N/A	M
4d. QI Process data (“5 Why’s”, fishbone diagram)				N/A	NM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)				N/A	M
4f. Literature review				M	M
Element 4 Overall Review Determination				M	PM

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Reduction in Falls Among Home and Community-Based Members in MLTSS**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 4 Overall Score				**100.0**	**50.0**
Element 4 Weighted Score				**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis				PM	PM
5b. Actions that target member, provider and MCO				PM	M
5c. New or enhanced, starting after baseline year				PM	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)				PM	PM
Element 5 Overall Review Determination				PM	PM
Element 5 Overall Score				**50.0**	**50.0**
Element 5 Weighted Score				**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals				M	NM
Element 6 Overall Review Determination				M	NM
Element 6 Overall Score				**100.0**	**0**
Element 6 Weighted Score				**5.0**	**0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)				M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan				M	PM

Aetna Better Health of New Jersey (ABHNJ) **PIP 1 Topic: Reduction in Falls Among Home and Community-Based Members in MLTSS**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.				PM	M
7d. Lessons learned & follow-up activities planned as a result				M	M
Element 7 Overall Review Determination				PM	PM
Element 7 Overall Score				**50.0**	**50.0**
Element 7 Weighted Score				**10.0**	**10.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented				M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods				NM	PM
Element 8 Overall Review Determination				PM	PM
Element 8 Overall Score				**50.0**	**50.0**
Element 8 Weighted Score				**10.0**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed				M	M
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**100.0**	**100.0**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**60.0**	**47.5**
Overall Rating	**N/A**	**N/A**	**N/A**	**60.0%**	**47.5%**

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

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components.

ABHNJ PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children

Aetna Better Health of New Jersey (ABHNJ) **PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		PM	M		
1b. Impacts the maximum proportion of members that is feasible		M	NM		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	NM		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM	M		
Element 1 Overall Review Determination		PM	PM		
Element 1 Overall Score		**50.0**	**50.0**		
Element 1 Weighted Score		**2.5**	**2.5**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	PM		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		PM	M		
2c. Objectives align aim and goals with interventions		M	PM		
Element 2 Overall Review Determination		PM	PM		
Element 2 Overall Score		**50.0**	**50.0**		
Element 2 Weighted Score		**2.5**	**2.5**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	PM		
3b. Performance indicators are measured consistently over time		M	M		

Aetna Better Health of New Jersey (ABHNJ) **PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		PM	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	PM		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	PM		
Element 3 Overall Review Determination		PM	PM		
Element 3 Overall Score		**50.0**	**50.0**		
Element 3 Weighted Score		**7.5**	**7.5**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data (“5 Why’s”, fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	PM		
Element 4 Overall Review Determination		M	PM		
Element 4 Overall Score		**100.0**	**50.0**		
Element 4 Weighted Score		**15.0**	**7.5**		

Aetna Better Health of New Jersey (ABHNJ) **PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M		
5b. Actions that target member, provider and MCO		M	M		
5c. New or enhanced, starting after baseline year		M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	NM		
Element 5 Overall Review Determination		M	PM		
Element 5 Overall Score		**100.0**	**50.0**		
Element 5 Weighted Score		**15.0**	**7.5**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	PM		
Element 6 Overall Review Determination		M	PM		
Element 6 Overall Score		**100.0**	**50.0**		
Element 6 Weighted Score		**5.0**	**2.5**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		PM	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	PM		
7d. Lessons learned & follow-up activities planned as a result		M	M		

Aetna Better Health of New Jersey (ABHNJ) **PIP 2: Improving Developmental Screening and Referral Rates to Early Intervention for Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[2]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination		PM	PM		
Element 7 Overall Score		**50.0**	**50.0**		
Element 7 Weighted Score		**10.0**	**10.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination		N/A			
Element 8 Overall Score		N/A	**N/A**		
Element 8 Weighted Score		N/A	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**57.5**	**40.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**71.9%**	**50%**	**N/A**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components.

[2] Aetna resubmitted their Year 1 Findings August PIP submission and this scoring reflects the updated resubmission.

ABHNJ: PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative

Aetna Better Health of New Jersey (ABHNJ) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM			
Element 1 Overall Review Determination	N/A	PM			
Element 1 Overall Score	N/A	**50.0**			
Element 1 Weighted Score	N/A	**2.5**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		PM			
Element 2 Overall Review Determination	N/A	PM			
Element 2 Overall Score	N/A	**50.0**			
Element 2 Weighted Score	N/A	**2.5**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			

Aetna Better Health of New Jersey (ABHNJ) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		PM			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	PM			
Element 3 Overall Score	N/A	**50.0**			
Element 3 Weighted Score	N/A	**7.5**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

Aetna Better Health of New Jersey (ABHNJ) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM			
Element 6 Overall Review Determination	N/A	PM			
Element 6 Overall Score	N/A	**50.0**			
Element 6 Weighted Score	N/A	**2.5**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Aetna Better Health of New Jersey (ABHNJ) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	N/A			
Element 7 Weighted Score	N/A	N/A			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

Aetna Better Health of New Jersey (ABHNJ) **PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM			
Element 1 Overall Review Determination	N/A	PM			
Element 1 Overall Score	N/A	**50.0**			
Element 1 Weighted Score	N/A	**2.5**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			

Aetna Better Health of New Jersey (ABHNJ) **PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		PM			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	PM			
Element 3 Overall Score	N/A	**50.0**			
Element 3 Weighted Score	N/A	**7.5**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

Aetna Better Health of New Jersey (ABHNJ) **PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		NM			
Element 6 Overall Review Determination	N/A	NM			
Element 6 Overall Score	N/A	**0**			
Element 6 Weighted Score	N/A	**0.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Aetna Better Health of New Jersey (ABHNJ) **PIP 4: Reduction in ER and IP Utilization through Enhanced Chronic Disease Management**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**0**			
Element 7 Weighted Score	N/A	**0.0**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	**N/A**			
Element 8 Weighted Score	N/A	**N/A**			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

ABHNJ Care Management Audits

ABHNJ 2019 Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2017 (n=101)	2018 (n=100)	% Point Change	2017 (n=27)	2018 (n=21)	% Point Change	2017 (n=35)	2018 (n=37)	% Point Change
Identification	85%	62%	-23	100%	100%	0	100%	100%	0
Outreach	83%	74%	-9	100%	100%	0	97%	95%	-2
Preventive Services	91%	51%	-40	87%	76%	-11	98%	91%	-7
Continuity of Care	100%	69%	-31	99%	99%	0	100%	91%	-9
Coordination of Services	100%	99%	-1	100%	100%	0	100%	96%	-4

ABHNJ MLTSS HCBS Care Management Audit – July 1, 2019–June 30, 2019

Performance Measure	Group[1]	July 2017 – June 2018			July 2018 – June 2019			PPD[2] to Prior Year
		D	N	Rate	D	N	Rate	PPD
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.[3]	Group C	66	24	36.4%	79	42	53.2%	16.8%
	Group D	36	10	27.8%	20	11	55.0%	27.2%
	Group E							0.0%
	Total	102	34	33.3%	99	53	53.5%	20.2%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	Group C	1	1	100.0%	3	0	0.0%	-100.0%
	Group D	1	0	0.0%	0	0	CNC	N/A
	Group E	23	14	60.9%	3	1	33.3%	-27.6%
	Total	25	15	60.0%	6	1	16.7%	-43.3%
#9a. Member's Plan of Care is amended based on change of member condition[5]	Group C	1	0	0.0%	1	0	0.0%	0.0%
	Group D	1	1	100.0%	2	1	50.0%	-50.0%
	Group E	1	1	100.0%	0	0	CNC	N/A
	Total	3	2	66.7%	3	1	33.3%	-33.4%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	Group C	52	52	100.0%	62	61	98.4%	-1.6%
	Group D	25	22	88.0%	12	12	100.0%	12.0%
	Group E	24	24	100.0%	25	22	88.0%	-12.0%
	Total	101	98	97.0%	99	95	96.0%	-1.0%
#11. Plans of Care developed using "person-centered principles" [7]	Group C	52	4	7.7%	62	0	0.0%	-7.7%
	Group D	25	1	4.0%	12	0	0.0%	-4.0%
	Group E	24	0	0.0%	25	0	0.0%	0.0%
	Total	101	5	5.0%	99	0	0.0%	-5.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	Group C	33	29	87.9%	46	38	82.6%	-5.3%
	Group D	25	18	72.0%	11	7	63.6%	-8.4%
	Group E	20	17	85.0%	20	17	85.0%	0.0%
	Total	78	64	82.1%	77	62	80.5%	-1.6%
#16. Member training on identifying/reporting critical incidents	Group C	52	51	98.1%	62	45	72.6%	-25.5%
	Group D	25	22	88.0%	12	9	75.0%	-13.0%
	Group E	24	23	95.8%	25	17	68.0%	-27.8%
	Total	101	96	95.0%	99	71	71.7%	-23.3%

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

[2]Percentage Point Difference

[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

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

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

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

[7] In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[8]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

ABHNJ Nursing Facility Audit: Plan of Care for Institutional Settings – July 1, 2017 – June 30, 2018

Tables A-E: Plan of Care for Institutional Settings

Table A

Facility and MCO Plan of Care	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	53	100	53%	77	100	77%	24%
Documented Review of the Facility Plan of Care by the Care Manager	29	100	29%	67	100	67%	38%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	48	53	91%	73	73	100%	9%

Table B

Plan of Care Development	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the Member and/or representative within 45 calendar days of enrollment into the MLTSS program (for Members newly enrolled in managed care and newly eligible for MLTSS during the review period)	1	42	2%	5	58	9%	7%
Agreement/Disagreement statements from the Plan(s) of Care on file during the review period were reviewed with the Member and/or representative at each visit	56	100	56%	59	100	59%	3%
Written Member Goals include all 5 Components; (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 – reviewed at each visit and documented progress)	85	100	85%	95	100	95%	10%
Plan of Care addresses formal and informal services. Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the Plan of Care, including the coordination of formal and informal services	100	100	100%	95	100	95%	-5%
Plan of Care developed with person-centered principles. POC documentation reflected a member-centric approach demonstrating the involvement of the Member and/or representative in the development of his/her goals	86	100	86%	95	100	95%	9%
Member and/or representative participated in the development of goals	88	100	88%	95	100	95%	7%

Table C

Transition Planning	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was identified for transfer to HCBS and was offered options, including transfer to the community	94	100	94%	97	100	97%	3%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	3	100	3%	12	100	12%	9%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	22	100	22%	21	100	21%	-1%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	98	98	100%	97	97	100%	0%
Members requiring coordination of care had **coordination of care** by the Care Manager	14	14	100%	4	4	100%	0%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission	0	0	N/A	0	0	N/A	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

Table D

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	1	7	14%	1	6	17%	3%
Member had a **New Jersey Choice Assessment completed** during the review period	95	100	95%	93	100	93%	-2%
NJCA completed for Members newly enrolled in managed care and newly eligible for MLTSS during the review period	41	44	93%	48	51	94%	1%
NJCA completed for Members enrolled in MLTSS with the MCO prior to the review period	54	56	96%	45	49	92%	-4%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	49	100	49%	89	100	89%	40%

Table E

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was admitted to a NF/SCNF prior to the review period	93 Members (93%)			94 Members (94%)			
Member was admitted to an NF/SCNF during the review period	7 members (7%)			6 members (6%)			
Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF	7	7	100%	6	6	100%	0.0%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	7	7	100%	5	6	83%	-17%
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	1	1	100%	1	1	100%	0%
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	N/A	0	0	N/A	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

ABHNJ NF/SCNF Members Transferred to HCBS – July 1, 2017 – June 30, 2018

NF/SCNF Member Transferred to HCBS	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	**N/A**
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	**N/A**
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	**N/A**
Person-centered transition Plan of Care on file for the Member	0	0	**N/A**
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	**N/A**
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	**N/A**
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	**N/A**
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

ABHNJ HCBS Members Transferred to a NF/SCNF – July 1, 2017 – June 30, 2018

HCBS Members Transferred to a NF/SCNF	Groups 3, 4		
	N	D	Rate
Care Manager presented and disclosed service delivery options with the Member, and **provided the Member with the opportunity to retain HCBS with a potential Risk Management Agreement** (not required for HCBS Members who were hospitalized and discharged directly to a NF/SCNF as a result of their condition and remained there)	0	0	**N/A**
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2019 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	14	7	14	9	5	0	64%	5	2	0
Quality Assessment and Performance Improvement	10	10	10	10	0	0	100%	0	0	0
Quality Management	18	17	18	16	2	0	89%	1	0	1
Efforts to Reduce Healthcare Disparities	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	43	44	44	0	0	100%	0	0	0
Provider Training and Performance	11	10	11	11	0	0	100%	0	1	0
Satisfaction	4	4	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	41	40	41	38	3	0	93%	0	1	3
Credentialing and Recredentialing	10	10	10	10	0	0	100%	0	0	0
Utilization Management	30	30	30	29	1	0	97%	0	2	1
Administration and Operations	13	13	13	13	0	0	100%	0	0	0
Management Information Systems	18	18	18	18	0	0	100%	0	0	0
TOTAL	**235**	**224**	**235**	**224**	**11**	**0**	**95%**	**6**	**6**	**5**

[1] A total of 71 elements were reviewed in the previous review period; of these 71, 58 were *Met* and 1 was *N/A*. Remaining elements (166) that were *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

AGNJ Performance Improvement Projects

AGNJ PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population

Amerigroup New Jersey (AGNJ) **PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		PM			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		PM			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	PM			
Element 2 Overall Score	N/A	**50.0**			
Element 2 Weighted Score	N/A	**2.5**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					

Amerigroup New Jersey (AGNJ) **PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			

Amerigroup New Jersey (AGNJ) **PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		PM			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM			
Element 6 Overall Review Determination	N/A	PM			
Element 6 Overall Score	N/A	**50.0**			
Element 6 Weighted Score	N/A	**2.5**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			

Amerigroup New Jersey (AGNJ) **PIP 1: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	N/A			
Element 7 Weighted Score	N/A	N/A			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**47.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**79.2%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

AGNJ PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination		M	M		
Element 1 Overall Score		**100.0**	**100.0**		
Element 1 Weighted Score		**5.0**	**5.0**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination		M	M		
Element 2 Overall Score		**100.0**	**100.0**		
Element 2 Weighted Score		**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM	M		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3b. Performance indicators are measured consistently over time		PM	M		
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination		PM	M		
Element 3 Overall Score		**50.0**	**100.0**		
Element 3 Weighted Score		**7.5**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		PM	PM		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		N/A	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination		PM	PM		
Element 4 Overall Score		**50.0**	**50.0**		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 4 Weighted Score		**7.5**	**7.5**		
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M		
5b. Actions that target member, provider and MCO		M	M		
5c. New or enhanced, starting after baseline year		M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM	PM		
Element 5 Overall Review Determination		PM	PM		
Element 5 Overall Score		**50.0**	**50.0**		
Element 5 Weighted Score		**7.5**	**7.5**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination		M	M		
Element 6 Overall Score		**100.0**	**100.0**		
Element 6 Weighted Score		**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		PM	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		PM	M		

Amerigroup New Jersey, Inc. (AGNJ) **PIP 2: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services For Members < 3 Years Old**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
7d. Lessons learned & follow-up activities planned as a result		PM	M		
Element 7 Overall Review Determination		PM	M		
Element 7 Overall Score		**50.0**	**100.0**		
Element 7 Weighted Score		**10.0**	**20.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination		N/A	N/A		
Element 8 Overall Score		N/A	N/A		
Element 8 Weighted Score		N/A	N/A		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**47.5**	**65.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**59.0%**	**81.3%**	**N/A**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

AGNJ PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%

Amerigroup New Jersey, Inc. (AGNJ) **PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed			M	M	
1b. Impacts the maximum proportion of members that is feasible			M	M	
1c. Potential for meaningful impact on member health, functional status or satisfaction			M	M	
1d. Reflects high-volume or high risk-conditions			M	M	
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)			M	M	
Element 1 Overall Review Determination			M	M	
Element 1 Overall Score			**100.0**	**100.0**	
Element 1 Weighted Score			**5.0**	**5.0**	
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals			M	PM	
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark			PM	M	
2c. Objectives align aim and goals with interventions			M	M	
Element 2 Overall Review Determination			PM	PM	
Element 2 Overall Score			**50.0**	**50.0**	
Element 2 Weighted Score			**2.5**	**2.5**	
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)			M	M	
3b. Performance indicators are measured consistently over time			M	M	
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes			M	M	

Amerigroup New Jersey, Inc. (AGNJ) **PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined			M	M	
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]			NM	NM	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.			N/A	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline			M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline			M	M	
Element 3 Overall Review Determination			PM	PM	
Element 3 Overall Score			**50.0**	**50.0**	
Element 3 Weighted Score			**7.5**	**7.5**	
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics			M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach			M	M	
4c. Provider input at focus groups and/or Quality Meetings			M	M	
4d. QI Process data (“5 Why’s”, fishbone diagram)			M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)			N/A	M	
4f. Literature review			M	M	
Element 4 Overall Review Determination			M	M	
Element 4 Overall Score			**100.0**	**100.0**	
Element 4 Weighted Score			**15.0**	**15.0**	
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					

Amerigroup New Jersey, Inc. (AGNJ) **PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
5a. Informed by barrier analysis			M	M	
5b. Actions that target member, provider and MCO			M	M	
5c. New or enhanced, starting after baseline year			PM	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)			PM	PM	
Element 5 Overall Review Determination			PM	PM	
Element 5 Overall Score			**50.0**	**50.0**	
Element 5 Weighted Score			**7.5**	**7.5**	
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals			PM	PM	
Element 6 Overall Review Determination			PM	PM	
Element 6 Overall Score			**50.0**	**50.0**	
Element 6 Weighted Score			**2.5**	**2.5**	
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)			PM	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan			M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.			M	PM	
7d. Lessons learned & follow-up activities planned as a result			PM	M	
Element 7 Overall Review Determination			PM	PM	
Element 7 Overall Score			**50.0**	**50.0**	
Element 7 Weighted Score			**10.0**	**10.0**	

Amerigroup New Jersey, Inc. (AGNJ) PIP 3: Reduction of the Amerigroup Preterm Birth Rate by 5%	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented			N/A	N/A	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods			N/A	N/A	
Element 8 Overall Review Determination			N/A	N/A	
Element 8 Overall Score			N/A	**0**	
Element 8 Weighted Score			N/A	**0**	
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)			N	N	
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**80.0**	**80.0**	**N/A**
Actual Weighted Total Score	**N/A**	**N/A**	**50.0**	**50.0**	**N/A**
Overall Rating	**N/A**	**N/A**	**62.5%**	**62.5%**	**N/A**

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

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		PM			
Element 3 Overall Review Determination	N/A	PM			
Element 3 Overall Score	N/A	**50.0**			
Element 3 Weighted Score	N/A	**7.5**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		PM			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	PM			
Element 4 Overall Score	N/A	**50.0**			
Element 4 Weighted Score	N/A	**7.5**			

Amerigroup New Jersey, Inc. (AGNJ) **PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		NM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	M			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Amerigroup New Jersey, Inc. (AGNJ) PIP 4: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	N/A			
Element 7 Weighted Score	N/A	N/A			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

AGNJ: PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		PM			
Element 1 Overall Review Determination	N/A	PM			
Element 1 Overall Score	N/A	**50.0**			
Element 1 Weighted Score	N/A	**2.5**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM			
3b. Performance indicators are measured consistently over time		M			

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	PM			
Element 3 Overall Score	N/A	**50.0**			
Element 3 Weighted Score	N/A	**7.5**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		NM			
Element 6 Overall Review Determination	N/A	NM			
Element 6 Overall Score	N/A	**0**			
Element 6 Weighted Score	N/A	**0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Amerigroup New Jersey, Inc. (AGNJ) **PIP 5: Decreasing Gaps in Care in Managed Long Term Services and Supports (MLTSS)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**N/A**			
Element 7 Weighted Score	N/A	**N/A**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented					
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods					
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**37.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**62.5%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

AGNJ Care Management Audits

AGNJ 2019 Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2017 (n=100)	2018 (n=100)	% Point Change	2017 (n=30)	2018 (n=20)	% Point Change	2017 (n=113)	2018 (n=61)	% Point Change
Identification	86%	84%	-2	97%	100%	3	100%	100%	0
Outreach	88%	80%	-8	97%	100%	3	100%	98%	-2
Preventive Services	88%	100%	12	87%	97%	10	97%	99%	2
Continuity of Care	96%	90%	-6	97%	100%	3	99%	99%	0
Coordination of Services	100%	89%	-11	99%	100%	1	99%	98%	-1

Performance Measure	Group[1]	July 2017 – June 2018			July 2018 – June 2019			PPD[2] to Prior Year
		D	N	Rate	D	N	Rate	PPD
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.[3]	Group C	32	6	18.8%	34	31	91.2%	72.4%
	Group D	72	17	23.6%	65	60	92.3%	68.7%
	Group E							
	Total	104	23	22.1%	99	91	91.9%	69.8%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	Group C	0	0	CNC	5	5	100.0%	N/A
	Group D	9	6	66.7%	19	19	100.0%	33.3%
	Group E	12	12	100.0%	16	16	100.0%	0.0%
	Total	21	18	85.7%	40	40	100.0%	14.3%
#9a. Member's Plan of Care is amended based on change of member condition[5]	Group C	2	0	0.0%	1	1	100.0%	100.0%
	Group D	12	5	41.7%	5	5	100.0%	58.3%
	Group E	3	2	66.7%	0	0	CNC	N/A
	Total	17	7	41.2%	6	6	100.0%	58.8%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	Group C	23	14	60.9%	23	23	100.0%	39.1%
	Group D	57	21	36.8%	51	51	100.0%	63.2%
	Group E	20	20	100.0%	26	26	100.0%	0.0%
	Total	100	55	55.0%	100	100	100.0%	45.0%
#11. Plans of Care developed using "person-centered principles" [7]	Group C	23	7	30.4%	23	23	100.0%	69.6%
	Group D	57	4	7.0%	51	51	100.0%	93.0%
	Group E	20	18	90.0%	26	26	100.0%	10.0%
	Total	100	29	29.0%	100	100	100.0%	71.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	Group C	11	1	9.1%	20	0	0.0%	-9.1%
	Group D	56	5	8.9%	50	2	4.0%	-4.9%
	Group E	14	3	21.4%	24	0	0.0%	-21.4%
	Total	81	9	11.1%	94	2	2.1%	-9.0%
#16. Member training on identifying/reporting critical incidents	Group C	23	21	91.3%	23	23	100.0%	8.7%
	Group D	57	55	96.5%	51	50	98.0%	1.5%
	Group E	20	19	95.0%	26	26	100.0%	5.0%
	Total	100	95	95.0%	100	99	99.0%	4.0%

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

[2]Percentage Point Difference

[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

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

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

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

[7] In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[8]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

AGNJ Nursing Facility Audit: Plan of Care for Institutional Settings – July 1, 2017 – June 30, 2018

Tables A-E: Plan of Care for Institutional Settings

Table A

Facility and MCO Plan of Care	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	60	100	60%	78	100	78%	18%
Documented Review of the Facility Plan of Care by the Care Manager	45	100	45%	78	100	78%	33%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	53	60	88%	76	77	99%	11%

Table B

Plan of Care Development	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the Member and/or representative within 45 calendar days of enrollment into the MLTSS program (for Members newly enrolled in managed care and newly eligible for MLTSS during the review period)	17	47	36%	33	35	94%	58%
Agreement/Disagreement statements from the Plan(s) of Care on file during the review period were reviewed with the Member and/or representative at each visit	23	100	23%	97	100	97.0%	74.0%
Written Member Goals include all 5 Components; (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 – reviewed at each visit and documented progress)	0	100	0%	95	100	95%	95%
Plan of Care addresses formal and informal services. Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the Plan of Care, including the coordination of formal and informal services	90	100	90%	98	100	98%	8%
Plan of Care developed with person-centered principles. POC documentation reflected a member-centric approach demonstrating the involvement of the Member and/or representative in the development of his/her goals	50	100	50%	97	100	97%	47%
Member and/or representative participated in the development of goals	58	100	58%	97	100	97%	39%

Table C

Transition Planning	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was identified for transfer to HCBS and was offered options, including transfer to the community	95	100	95%	100	100	100%	5%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	4	100	4%	33	100	33%	29%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	40	100	40%	48	100	48%	8%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	53	99	54%	99	100	99%	45%
Members requiring coordination of care had **coordination of care** by the Care Manager	21	32	66%	90	99	91%	25%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission	0	0	N/A	0	0	N/A	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

Table D

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	11	0%	3	3	100%	100%
Member had a **New Jersey Choice Assessment completed** during the review period	86	100	86%	90	99	91%	5%
NJCA completed for Members newly enrolled in managed care and newly eligible for MLTSS during the review period	45	54	83%	16	19	84%	1%
NJCA completed for Members enrolled in MLTSS with the MCO prior to the review period	41	46	89%	74	80	93%	4%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	55	100	55%	96	100	96%	41%

Table E

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was admitted to a NF/SCNF prior to the review period	94 Members (94%)			92 Members (92%)			
Member was admitted to an NF/SCNF during the review period	6 members (7%)			8 members (6%)			
Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF	6	6	100%	5	8	63%	-37%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	5	6	83%	4	8	50%	-33%
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	N/A	1	2	50%	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	N/A	1	2	50%	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

AGNJ NF/SCNF Members Transferred to HCBS – July 1, 2017 – June 30, 2018

NF/SCNF Member Transferred to HCBS	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	**N/A**
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	**N/A**
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	**N/A**
Person-centered transition Plan of Care on file for the Member	0	0	**N/A**
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	**N/A**
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	**N/A**
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	**N/A**
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

AGNJ HCBS Members Transferred to a NF/SCNF – July 1, 2017 – June 30, 2018

HCBS Members Transferred to a NF/SCNF	Groups 3, 4		
	N	D	Rate
Care Manager presented and disclosed service delivery options with the Member, and **provided the Member with the opportunity to retain HCBS with a potential Risk Management Agreement** (not required for HCBS Members who were hospitalized and discharged directly to a NF/SCNF as a result of their condition and remained there)	0	0	**N/A**
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2019 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	14	13	14	11	3	0	79%	1	0	2
Quality Assessment and Performance Improvement	10	10	10	10	0	0	100%	0	0	0
Quality Management	18	17	18	16	2	0	89%	1	0	1
Efforts to Reduce Healthcare Disparities	5	4	5	5	0	0	100%	0	1	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	42	44	44	0	0	100%	0	1	0
Provider Training and Performance	11	11	11	11	0	0	100%	0	0	0
Satisfaction	4	4	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	41	39	41	36	5	0	88%	2	0	3
Credentialing and Recredentialing	10	10	10	10	0	0	100%	0	0	0
Utilization Management	30	32	30	29	1	0	97%	0	0	1
Administration and Operations	13	12	13	13	0	0	100%	0	1	0
Management Information Systems	18	18	18	18	0	0	100%	0	0	0
TOTAL	**235**	**229**	**235**	**224**	**11**	**0**	**95%**	**4**	**3**	**7**

[1] A total of 130 elements were reviewed in the previous review period; of these 130, 122 were *Met* and 1 was *N/A*. Remaining elements (107) that were *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

HNJH Performance Improvement Projects

HNJH PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Supports (MLTSS) Members

Horizon NJ Health (HNJH) **PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Support (MLTSS) Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed				M	M
1b. Impacts the maximum proportion of members that is feasible				M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction				M	M
1d. Reflects high-volume or high risk-conditions				M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)				M	M
Element 1 Overall Review Determination				M	M
Element 1 Overall Score				**100.0**	**100.0**
Element 1 Weighted Score				**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals				PM	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark				PM	M
2c. Objectives align aim and goals with interventions				M	M
Element 2 Overall Review Determination				PM	M
Element 2 Overall Score				**50.0**	**100.0**
Element 2 Weighted Score				**2.5**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					

Horizon NJ Health (HNJH) **PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Support (MLTSS) Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)				M	M
3b. Performance indicators are measured consistently over time				M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes				M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined				M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]				M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.				N/A	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline				M	M
3h. Study design specifies data analysis procedures with a corresponding timeline				M	M
Element 3 Overall Review Determination				M	M
Element 3 Overall Score				**100.0**	**100.0**
Element 3 Weighted Score				**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics				N/A	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach				M	M
4c. Provider input at focus groups and/or Quality Meetings				M	M
4d. QI Process data (“5 Why’s”, fishbone diagram)				M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)				N/A	M
4f. Literature review				M	M

Horizon NJ Health (HNJH) **PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Support (MLTSS) Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 4 Overall Review Determination				M	M
Element 4 Overall Score				**100.0**	**100.0**
Element 4 Weighted Score				**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis				PM	M
5b. Actions that target member, provider and MCO				PM	M
5c. New or enhanced, starting after baseline year				M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)				PM	PM
Element 5 Overall Review Determination				PM	PM
Element 5 Overall Score				**50.0**	**50.0**
Element 5 Weighted Score				**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals				PM	M
Element 6 Overall Review Determination				PM	M
Element 6 Overall Score				**50.0**	**100.0**
Element 6 Weighted Score				**2.5**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)				PM	M

Horizon NJ Health (HNJH) **PIP 1: Prevention of Recurrent Falls Among Managed Long Term Services and Support (MLTSS) Members**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan				M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.				M	M
7d. Lessons learned & follow-up activities planned as a result				N/A	M
Element 7 Overall Review Determination				PM	M
Element 7 Overall Score				**50.0**	**100.0**
Element 7 Weighted Score				**10.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented				M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods				N/A	M
Element 8 Overall Review Determination				M	M
Element 8 Overall Score				**100.0**	**100.0**
Element 8 Weighted Score				**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed				M	M
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**100.0**	**100.0**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**77.5**	**92.5**
Overall Rating	**N/A**	**N/A**	**N/A**	**78.0%**	**92.5%**

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

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components

HNJH PIP 2: Developmental Screening and Early Intervention in Young Children

Horizon NJ Health (HNJH) **PIP 2: Developmental Screening and Early Intervention in Young Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination		M	M		
Element 1 Overall Score		**100.0**	**100.0**		
Element 1 Weighted Score		**5.0**	**5.0**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination		M	M		
Element 2 Overall Score		**100.0**	**100.0**		
Element 2 Weighted Score		**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		M	M		

Horizon NJ Health (HNJH) PIP 2: Developmental Screening and Early Intervention in Young Children	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		PM	PM		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		N/A	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination		PM	PM		
Element 3 Overall Score		**50.0**	**50.0**		
Element 3 Weighted Score		**7.5**	**7.5**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination		M	M		
Element 4 Overall Score		**100.0**	**100.0**		
Element 4 Weighted Score		**15.0**	**15.0**		

Horizon NJ Health (HNJH) **PIP 2: Developmental Screening and Early Intervention in Young Children**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M		
5b. Actions that target member, provider and MCO		M	M		
5c. New or enhanced, starting after baseline year		M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M		
Element 5 Overall Review Determination		M	M		
Element 5 Overall Score		**100.0**	**100.0**		
Element 5 Weighted Score		**15.0**	**15.0**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination		M	M		
Element 6 Overall Score		**100.0**	**100.0**		
Element 6 Weighted Score		**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M		
7d. Lessons learned & follow-up activities planned as a result		M	M		
Element 7 Overall Review Determination		M	M		

Horizon NJ Health (HNJH) PIP 2: Developmental Screening and Early Intervention in Young Children	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Score		**100.0**	**100.0**		
Element 7 Weighted Score		**20.0**	**20.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination		N/A	N/A		
Element 8 Overall Score		N/A	N/A		
Element 8 Weighted Score		N/A	N/A		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**N/A**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

Horizon NJ Health (HNJH) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			

Horizon NJ Health (HNJH) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

Horizon NJ Health (HNJH) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M			
Element 5 Overall Review Determination	N/A	M			
Element 5 Overall Score	N/A	**100.0**			
Element 5 Weighted Score	N/A	**15.0**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	M			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Horizon NJ Health (HNJH) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**N/A**			
Element 7 Weighted Score	N/A	**N/A**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**100%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

Horizon NJ Health (HNJH) **PIP 4: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			

Horizon NJ Health (HNJH) **PIP 4: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data ("5 Why's", fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

Horizon NJ Health (HNJH) **PIP 4: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M			
Element 5 Overall Review Determination	N/A	M			
Element 5 Overall Score	N/A	**100.0**			
Element 5 Weighted Score	N/A	**15.0**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	M			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

Horizon NJ Health (HNJH) **PIP 4: Reducing Admissions, Readmissions and Gaps in Service for Members with Congestive Heart Failure in the Horizon NJ Health MLTSS Medicaid Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**0**			
Element 7 Weighted Score	N/A	**0.0**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	**N/A**			
Element 8 Weighted Score	N/A	**N/A**			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**100.0%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

HNJH Care Management Audits

HNJH 2019 Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2017 (n=100)	2018 (n=100)	% Point Change	2017 (n=100)	2018 (n=70)	% Point Change	2017 (n=104)	2018 (n=100)	% Point Change
Identification	83%	70%	-13	100%	100%	0	100%	100%	0
Outreach	72%	57%	-15	87%	98%	11	100%	100%	0
Preventive Services	89%	76%	-13	94%	96%	2	98%	91%	-7
Continuity of Care	98%	88%	-10	90%	93%	3	100%	100%	0
Coordination of Services	100%	86%	-14	100%	81%	-19	100%	100%	0

HNJH MLTSS HCBS Care Management Audit – July 1, 2018–June 30, 2019

Performance Measure	Group[1]	July 2017 – June 2018			July 2018 – June 2019			PPD[2] to Prior Year
		D	N	Rate	D	N	Rate	PPD
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.[3]	Group C	25	19	76.0%	25	18	72.0%	-4.0%
	Group D	78	66	84.6%	73	67	91.8%	7.2%
	Group E							
	Total	103	85	82.5%	98	85	86.7%	4.2%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	Group C	2	2	100.0%	12	12	100.0%	0.0%
	Group D	8	7	87.5%	23	23	100.0%	12.5%
	Group E	20	17	85.0%	11	11	100.0%	15.0%
	Total	30	26	86.7%	46	46	100.0%	13.3%
#9a. Member's Plan of Care is amended based on change of member condition[5]	Group C	5	2	40.0%	1	1	100.0%	60.0%
	Group D	9	9	100.0%	3	3	100.0%	0.0%
	Group E	5	5	100.0%	1	1	100.0%	0.0%
	Total	19	16	84.2%	5	5	100.0%	15.8%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	Group C	19	19	100.0%	18	18	100.0%	0.0%
	Group D	60	60	100.0%	55	55	100.0%	0.0%
	Group E	22	22	100.0%	27	27	100.0%	0.0%
	Total	101	101	100.0%	100	100	100.0%	0.0%
#11. Plans of Care developed using "person-centered principles" [7]	Group C	19	1	5.3%	18	10	55.6%	50.3%
	Group D	60	2	3.3%	55	38	69.1%	65.8%
	Group E	22	0	0.0%	27	14	51.9%	51.9%
	Total	101	3	3.0%	100	62	62.0%	59.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	Group C	13	13	100.0%	12	11	91.7%	-8.3%
	Group D	56	54	96.4%	54	53	98.1%	1.7%
	Group E	19	19	100.0%	23	21	91.3%	-8.7%
	Total	88	86	97.7%	89	85	95.5%	-2.2%
#16. Member training on identifying/reporting critical incidents	Group C	19	18	94.7%	18	18	100.0%	5.3%
	Group D	60	60	100.0%	55	55	100.0%	0.0%
	Group E	22	22	100.0%	27	27	100.0%	0.0%
	Total	101	100	99.0%	100	100	100.0%	1.0%

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

[2]Percentage Point Difference

[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

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

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

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

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

HNJH Nursing Facility Audit: Plan of Care for Institutional Settings – July 1, 2017–June 30, 2018

Tables A-E: Plan of Care for Institutional Settings

Table A

Facility and MCO Plan of Care	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	75	100	75%	79	100	79%	4%
Documented Review of the Facility Plan of Care by the Care Manager	52	100	52%	79	100	79%	27%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	58	75	77%	79	80	99%	22%

Table B

Plan of Care Development	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the Member and/or representative within 45 calendar days of enrollment into the MLTSS program (for Members newly enrolled in managed care and newly eligible for MLTSS during the review period)	18	35	51%	39	40	98%	47%
Agreement/Disagreement statements from the Plan(s) of Care on file during the review period were reviewed with the Member and/or representative at each visit	80	100	80%	97	100	97%	17%
Written Member Goals include all 5 Components; (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 – reviewed at each visit and documented progress)	3	100	3%	100	100	100%	97%
Plan of Care addresses formal and informal services. Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the Plan of Care, including the coordination of formal and informal services	98	100	98%	100	100	100%	2%
Plan of Care developed with person-centered principles. POC documentation reflected a member-centric approach demonstrating the involvement of the Member and/or representative in the development of his/her goals	78	100	78%	100	100	100%	22%
Member and/or representative participated in the development of goals	84	100	84%	100	100	100%	16%

Table C

Transition Planning	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was identified for transfer to HCBS and was offered options, including transfer to the community	91	100	91%	100	100	100%	9%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	21	100	21%	94	100	94%	73%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	63	100	63%	68	100	68%	5%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	93	98	95%	100	100	100%	5%
Members requiring coordination of care had **coordination of care** by the Care Manager	23	25	92%	97	97	100%	8%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission	0	0	N/A	97	97	100%	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

Table D

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	9	23	39%	6	6	100%	61%
Member had a **New Jersey Choice Assessment completed** during the review period	93	100	93%	100	100	100%	7%
NJCA completed for Members newly enrolled in care and newly eligible for MLTSS during the review period	59	62	95%	24	24	100%	5%
NJCA completed for Members enrolled in MLTSS with the MCO prior to the review period	34	38	89%	76	76	100%	11%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	76	100	76%	82	100	82%	6%

Table E

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was admitted to a NF/SCNF prior to the review period	89 Members (89%)			85 Members (85%)			
Member was admitted to an NF/SCNF during the review period	11 members (11%)			15 members (15%)			
Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF	8	11	73%	15	15	100%	27%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	7	11	64%	15	15	100%	36%
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	2	0%	5	5	100%	100%
Members who had PASSR Level II forms indicating a need for Specialized Services Setting was coordinated appropriately with DDD/DMHAS	0	2	0%	5	5	100%	100%

N/A: Indicates a denominator of 0

CNC: Could not calculate

HNJH NF/SCNF Members Transferred to HCBS – July 1, 2017–June 30, 2018

NF/SCNF Member Transferred to HCBS	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	**N/A**
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	**N/A**
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	**N/A**
Person-centered transition Plan of Care on file for the Member	0	0	**N/A**
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	**N/A**
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	**N/A**
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	**N/A**
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

HNJH HCBS Members Transferred to a NF/SCNF – July 1, 2017–June 30, 2018

HCBS Members Transferred to a NF/SCNF	Groups 3, 4		
	N	D	Rate
Care Manager presented and disclosed service delivery options with the Member, and **provided the Member with the opportunity to retain HCBS with a potential Risk Management Agreement** (not required for HCBS Members who were hospitalized and discharged directly to a NF/SCNF as a result of their condition and remained there)	0	0	**N/A**
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2019 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	14	11	14	10	4	0	71%	3	0	1
Quality Assessment and Performance Improvement	10	10	10	10	0	0	100%	0	0	0
Quality Management	18	17	18	14	4	0	78%	1	0	3
Efforts to Reduce Healthcare Disparities	5	5	5	4	1	0	80%	0	0	1
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	43	44	43	1	0	98%	0	0	1
Provider Training and Performance	11	10	11	10	1	0	91%	1	0	0
Satisfaction	4	4	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	41	39	41	37	4	0	90%	1	1	3
Credentialing and Recredentialing	10	8	10	9	1	0	90%	1	1	0
Utilization Management	30	24	30	22	6	2	79%	3	4	3
Administration and Operations	13	12	13	12	1	0	92%	1	0	0
Management Information Systems	18	18	18	18	0	0	100%	0	0	0
TOTAL	**235**	**218**	**235**	**210**	**23**	**2**	**90%**	**11**	**6**	**12**

[1] A total of 107 elements were reviewed in the previous review period; of these 107, 88 were *Met* and 3 were *N/A*. Remaining elements (130) that were *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

UHCCP Performance Improvement Projects

UHCCP PIP 1: Prevention of Recurrent Falls in MLTSS Members with History of Falls

UnitedHealthcare Community Plan (UHCCP) **PIP 1: Preventing Recurrent Falls in MLTSS Members with History of Falls**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed				M	M
1b. Impacts the maximum proportion of members that is feasible				M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction				M	M
1d. Reflects high-volume or high risk-conditions				M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)				M	M
Element 1 Overall Review Determination				M	M
Element 1 Overall Score				**100.0**	**100.0**
Element 1 Weighted Score				**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals				PM	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark				PM	M
2c. Objectives align aim and goals with interventions				M	M
Element 2 Overall Review Determination				PM	M
Element 2 Overall Score				**50.0**	**100.0**
Element 2 Weighted Score				**2.5**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)				PM	PM
3b. Performance indicators are measured consistently over time				M	M

UnitedHealthcare Community Plan (UHCCP) **PIP 1: Preventing Recurrent Falls in MLTSS Members with History of Falls**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes				M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined				M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]				M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.				N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline				M	M
3h. Study design specifies data analysis procedures with a corresponding timeline				M	M
Element 3 Overall Review Determination				PM	PM
Element 3 Overall Score				**50.0**	**50.0**
Element 3 Weighted Score				**7.5**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics				M	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach				N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings				N/A	N/A
4d. QI Process data (“5 Why’s”, fishbone diagram)				M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)				N/A	N/A
4f. Literature review				M	M
Element 4 Overall Review Determination				M	M
Element 4 Overall Score				**100.0**	**100.0**
Element 4 Weighted Score				**15.0**	**15.0**

UnitedHealthcare Community Plan (UHCCP) PIP 1: Preventing Recurrent Falls in MLTSS Members with History of Falls	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis				M	M
5b. Actions that target member, provider and MCO				M	M
5c. New or enhanced, starting after baseline year				M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)				PM	PM
Element 5 Overall Review Determination				PM	PM
Element 5 Overall Score				**50.0**	**50.0**
Element 5 Weighted Score				**7.5**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals				PM	PM
Element 6 Overall Review Determination				PM	PM
Element 6 Overall Score				**50.0**	**50.0**
Element 6 Weighted Score				**2.5**	**2.5**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)				M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan				M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.				M	M
7d. Lessons learned & follow-up activities planned as a result				M	M
Element 7 Overall Review Determination				M	M

UnitedHealthcare Community Plan (UHCCP) PIP 1: Preventing Recurrent Falls in MLTSS Members with History of Falls	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 7 Overall Score				**100.0**	**100.0**
Element 7 Weighted Score				**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented				N/A	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods				N/A	PM
Element 8 Overall Review Determination				N/A	PM
Element 8 Overall Score				**N/A**	**50.0**
Element 8 Weighted Score				**N/A**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed(Y=Yes N=No)				M	N
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**100.0**	**100.0**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**60.0**	**72.5**
Overall Rating	**N/A**	**N/A**	**N/A**	**60.0%**	**72.5%**

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

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components

UHCCP PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)

UnitedHealthcare Community Plan (UHCCP) **PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination		M	M		
Element 1 Overall Score		**100.0**	**100.0**		
Element 1 Weighted Score		**5.0**	**5.0**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		PM	M		
Element 2 Overall Review Determination		PM	M		
Element 2 Overall Score		**50.0**	**100.0**		
Element 2 Weighted Score		**2.5**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	PM		
3b. Performance indicators are measured consistently over time		M	M		

UnitedHealthcare Community Plan (UHCCP) PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		N/A	N/A		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination		M	PM		
Element 3 Overall Score		**100.0**	**50.0**		
Element 3 Weighted Score		**15.0**	**7.5**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	N/A		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	N/A		
4d. QI Process data ("5 Why's", fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	N/A		
4f. Literature review		M	N/A		
Element 4 Overall Review Determination		M	M		
Element 4 Overall Score		**100.0**	**100.0**		
Element 4 Weighted Score		**15.0**	**15.0**		

UnitedHealthcare Community Plan (UHCCP) **PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M		
5b. Actions that target member, provider and MCO		PM	M		
5c. New or enhanced, starting after baseline year		PM	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M		
Element 5 Overall Review Determination		PM	M		
Element 5 Overall Score		**50.0**	**100.0**		
Element 5 Weighted Score		**7.5**	**15.0**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination		M	M		
Element 6 Overall Score		**100.0**	**100.0**		
Element 6 Weighted Score		**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M		
7d. Lessons learned & follow-up activities planned as a result		PM	M		

UnitedHealthcare Community Plan (UHCCP) **PIP 2: Early Intervention for Children in Lead Case Management (Age Birth to 2.99 Years Old)**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination		PM	M		
Element 7 Overall Score		**50.0**	**100.0**		
Element 7 Weighted Score		**10.0**	**20.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination		N/A	N/A		
Element 8 Overall Score		N/A	**N/A**		
Element 8 Weighted Score		N/A	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		Y	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**60.0**	**72.5**	**N/A**	**N/A**
Overall Rating	**N/A**	**75.0%**	**90.6%**	**N/A**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

UnitedHealthcare Community Plan (UHCCP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	**M**			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	**M**			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		PM			
3b. Performance indicators are measured consistently over time		M			

UnitedHealthcare Community Plan (UHCCP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	**PM**			
Element 3 Overall Score	N/A	**50.0**			
Element 3 Weighted Score	N/A	**7.5**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data ("5 Why's", fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	**M**			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

UnitedHealthcare Community Plan (UHCCP) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	**PM**			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	**M**			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

UnitedHealthcare Community Plan (UHCCP) **PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	**N/A**			
Element 7 Overall Score	N/A	**N/A**			
Element 7 Weighted Score	N/A	**N/A**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	**N/A**			
Element 8 Overall Score	N/A	**N/A**			
Element 8 Weighted Score	N/A	**N/A**			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**45.0**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**75.0%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

UHCCP PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population

UnitedHealthcare Community Plan (UHCCP) **PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		PM			
Element 2 Overall Review Determination	N/A	PM			
Element 2 Overall Score	N/A	**50.0**			
Element 2 Weighted Score	N/A	**2.5**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			

UnitedHealthcare Community Plan (UHCCP) **PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3b. Performance indicators are measured consistently over time		M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		N/A			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data (“5 Why’s”, fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			

UnitedHealthcare Community Plan (UHCCP) **PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		PM			
Element 6 Overall Review Determination	N/A	PM			
Element 6 Overall Score	N/A	**50.0**			
Element 6 Weighted Score	N/A	**2.5**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			

UnitedHealthcare Community Plan (UHCCP) PIP 4: Improving Influenza and Pneumococcal Immunization Rates in the Managed Long Term Services and Supports (MLTSS) Home and Community Based Services (HCBS) Population	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**N/A**			
Element 7 Weighted Score	N/A	**N/A**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	**N/A**			
Element 8 Weighted Score	N/A	**N/A**			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**47.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**79.2%**	**N/A**	**N/A**	**N/A**

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

[1]Proposal Findings were not scored.

UHCCP Care Management Audits

UHCCP 2019 Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2017 (n=100)	2018 (n=100)	% Point Change	2017 (n=53)	2018 (n=47)	% Point Change	2017 (n=100)	2018 (n=100)	% Point Change
Identification	96%	58%	-38	100%	100%	0	100%	100%	0
Outreach	85%	57%	-28	99%	96%	-3	100%	96%	-4
Preventive Services	70%	65%	-5	87%	100%	13	94%	98%	4
Continuity of Care	90%	64%	-26	99%	96%	-3	99%	91%	-8
Coordination of Services	100%	97%	-3	97%	100%	3	99%	100%	1

Performance Measure	Group[1]	July 2017 – June 2018			July 2018 – June 2019			PPD[2] to Prior Year
		D	N	Rate	D	N	Rate	PPD
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.[3]	Group C	34	17	50.0%	44	11	25.0%	-25.0%
	Group D	69	43	62.3%	54	21	38.9%	-23.4%
	Group E							
	Total	103	60	58.3%	98	32	32.7%	-25.6%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	Group C	2	0	0.0%	2	1	50.0%	50.0%
	Group D	2	2	100.0%	4	4	100.0%	0.0%
	Group E	22	18	81.8%	2	1	50.0%	-31.8%
	Total	26	20	76.9%	8	6	75.0%	-1.9%
#9a. Member's Plan of Care is amended based on change of member condition[5]	Group C	0	0	CNC	4	3	75.0%	N/A
	Group D	0	0	CNC	12	10	83.3%	N/A
	Group E	1	0	0.0%	3	1	33.3%	33.3%
	Total	1	0	0.0%	19	14	73.7%	73.7%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	Group C	24	21	87.5%	32	28	87.5%	0.0%
	Group D	54	52	96.3%	41	41	100.0%	3.7%
	Group E	22	18	81.8%	27	24	88.9%	7.1%
	Total	100	91	91.0%	100	93	93.0%	2.0%
#11. Plans of Care developed using "person-centered principles" [7]	Group C	24	0	0.0%	32	1	3.1%	3.1%
	Group D	54	0	0.0%	41	1	2.4%	2.4%
	Group E	22	0	0.0%	27	0	0.0%	0.0%
	Total	100	0	0.0%	100	2	2.0%	2.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	Group C	14	14	100.0%	19	17	89.5%	-10.5%
	Group D	54	52	96.3%	38	36	94.7%	-1.6%
	Group E	14	13	92.9%	18	15	83.3%	-9.6%
	Total	82	79	96.3%	75	68	90.7%	-5.6%
#16. Member training on identifying/reporting critical incidents	Group C	24	24	100.0%	32	28	87.5%	-12.5%
	Group D	54	53	98.1%	41	40	97.6%	-0.5%
	Group E	22	18	81.8%	27	24	88.9%	7.1%
	Total	100	95	95.0%	100	92	92.0%	-3.0%

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

[2]Percentage Point Difference

[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

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

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

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

[7] In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[8]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

UHCCP Nursing Facility Audit: Plan of Care for Institutional Settings – July 1, 2017–June 30, 2018

Tables A-E: Plan of Care for Institutional Settings

Table A

Facility and MCO Plan of Care	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	29	100	29%	66	100	66%	37%
Documented Review of the Facility Plan of Care by the Care Manager	33	100	33%	37	100	37%	4%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	19	29	66%	56	57	98%	32%

Table B

Plan of Care Development	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the Member and/or representative within 45 calendar days of enrollment into the MLTSS program (for Members newly enrolled in managed care and newly eligible for MLTSS during the review period)	11	39	28%	5	26	19%	-9%
Agreement/Disagreement statements from the Plan(s) of Care on file during the review period were reviewed with the Member and/or representative at each visit	55	100	55%	70	100	70%	15%
Written Member Goals include all 5 Components; (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 – reviewed at each visit and documented progress)	29	100	29%	64	100	64%	35%
Plan of Care addresses formal and informal services. Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the Plan of Care, including the coordination of formal and informal services	91	100	91%	83	100	83%	-8%
Plan of Care developed with person-centered principles. POC documentation reflected a member-centric approach demonstrating the involvement of the Member and/or representative in the development of his/her goals	60	100	60%	72	100	72%	12%
Member and/or representative participated in the development of goals	62	100	62%	76	100	76%	14%

Table C

Transition Planning	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was identified for transfer to HCBS and was offered options, including transfer to the community	93	100	93%	93	100	93%	0%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	2	100	2%	11	100	11%	9%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	37	100	37%	19	100	19%	-18%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	73	88	83%	98	98	100%	17%
Members requiring coordination of care had **coordination of care** by the Care Manager	7	7	100%	1	2	50%	-50%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission	0	1	0%	0	0	N/A	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

Table D

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	3	7	43%	2	23	9%	-34%
Member had a **New Jersey Choice Assessment completed** during the review period	76	100	76%	89	100	89%	13%
NJCA completed for Members newly enrolled in care and newly eligible for MLTSS during the review period	38	49	78%	25	27	93%	15%
NJCA completed for Members enrolled in MLTSS with the MCO prior to the review period	38	51	75%	64	73	88%	13%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	42	99	42%	63	100	63%	21%

Table E

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was admitted to a NF/SCNF prior to the review period	92 Members (92%)			92 Members (92%)			
Member was admitted to an NF/SCNF during the review period	8 members (8%)			8 members (8%)			
Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF	6	8	75%	7	8	88%	13%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	4	8	50%	5	8	63%	13%
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	2	0%	1	2	50%	50%
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	1	0%	1	1	100%	100%

N/A: Indicates a denominator of 0

CNC: Could not calculate

UHCCP NF/SCNF Members Transferred to HCBS – July 1, 2017–June 30, 2018

NF/SCNF Member Transferred to HCBS	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	1	1	100%
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	1	0%
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	1	1	100%
Person-centered transition Plan of Care on file for the Member	1	1	100%
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	1	1	100%
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	1	1	100%
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	1	1	100%
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	1	0%

Reviews of this population are optional and not scored

UHCCP HCBS Members Transferred to a NF/SCNF – July 1, 2017–June 30, 2018

HCBS Members Transferred to a NF/SCNF	Groups 3, 4		
	N	D	Rate
Care Manager presented and disclosed service delivery options with the Member, and **provided the Member with the opportunity to retain HCBS with a potential Risk Management Agreement** (not required for HCBS Members who were hospitalized and discharged directly to a NF/SCNF as a result of their condition and remained there)	0	0	**N/A**
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

WCHP 2019 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	14	7	10	4	8	6	0	57%	6	1	0
Quality Assessment and Performance Improvement	10	10	10	10	10	0	0	100%	0	0	0
Quality Management	18	17	9	8	17	1	0	94%	1	0	0
Efforts to Reduce Healthcare Disparities	5	5	5	5	5	0	0	100%	0	0	0
Committee Structure	9	9	3	3	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	43	12	12	44	0	0	100%	0	0	0
Provider Training and Performance	11	11	4	4	11	0	0	100%	0	0	0
Satisfaction	4	4	0	0	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	4	4	8	0	0	100%	0	0	0
Care Management and Continuity of Care	41	41	13	13	41	0	0	100%	0	0	0
Credentialing and Recredentialing	10	10	3	3	10	0	0	100%	0	0	0
Utilization Management	30	31	14	14	30	0	0	100%	0	1	0
Administration and Operations	13	13	3	3	13	0	0	100%	0	0	0
Management Information Systems	18	16	4	4	18	0	0	100%	0	1	0
TOTAL	**235**	**225**	**94**	**87**	**228**	**7**	**0**	**97%**	**7**	**3**	**0**

[1] All existing elements were subject to review in the previous review period.

[2] Elements *Not Met* or *N/A* in prior review, elements *Met* in prior year, but subject to review annually, as well as elements new in this review period. As a result, the sum of "Met Prior Year" and "Subject to Review" might exceed the total number of elements for some standards.

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

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

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

WCHP Performance Improvement Projects

WCHP PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older That Fall

WellCare Health Plans, Inc. of New Jersey (WCHP) **PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older That Fall**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed				M	M
1b. Impacts the maximum proportion of members that is feasible				M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction				M	M
1d. Reflects high-volume or high risk-conditions				M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)				M	M
Element 1 Overall Review Determination				M	M
Element 1 Overall Score				**100.0**	**100.0**
Element 1 Weighted Score				**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals				M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark				M	M
2c. Objectives align aim and goals with interventions				M	M
Element 2 Overall Review Determination				M	M
Element 2 Overall Score				**100.0**	**100.0**
Element 2 Weighted Score				**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					

WellCare Health Plans, Inc. of New Jersey (WCHP) PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older That Fall	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)				M	M
3b. Performance indicators are measured consistently over time				M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes				M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined				M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]				M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.				N/A	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline				M	M
3h. Study design specifies data analysis procedures with a corresponding timeline				M	M
Element 3 Overall Review Determination				M	M
Element 3 Overall Score				**100.0**	**100.0**
Element 3 Weighted Score				**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics				N/A	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach				N/A	M
4c. Provider input at focus groups and/or Quality Meetings				N/A	M
4d. QI Process data ("5 Why's", fishbone diagram)				M	M
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)				N/A	M
4f. Literature review				M	M

WellCare Health Plans, Inc. of New Jersey (WCHP) PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older That Fall	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
Element 4 Overall Review Determination				M	M
Element 4 Overall Score				**100.0**	**100.0**
Element 4 Weighted Score				**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis				M	M
5b. Actions that target member, provider and MCO				M	M
5c. New or enhanced, starting after baseline year				M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)				M	PM
Element 5 Overall Review Determination				M	PM
Element 5 Overall Score				**100.0**	**50.0**
Element 5 Weighted Score				**15.0**	**7.5**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals				PM	M
Element 6 Overall Review Determination				PM	M
Element 6 Overall Score				**50.0**	**100.0**
Element 6 Weighted Score				**2.5**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)				PM	M

WellCare Health Plans, Inc. of New Jersey (WCHP) PIP 1: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older That Fall	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings[1]	Year 2 Findings[1]	Sustainability Findings	Final Report Findings
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan				M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.				M	M
7d. Lessons learned & follow-up activities planned as a result				N/A	M
Element 7 Overall Review Determination				PM	M
Element 7 Overall Score				**50.0**	**100.0**
Element 7 Weighted Score				**10.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented				M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods				M	M
Element 8 Overall Review Determination				M	M
Element 8 Overall Score				**100.0**	**100.0**
Element 8 Weighted Score				**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed				M	M
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**N/A**	**N/A**	**100.0**	**100.0**
Actual Weighted Total Score	**N/A**	**N/A**	**N/A**	**87.5**	**92.5**
Overall Rating	**N/A**	**N/A**	**N/A**	**88.0%**	**92.5%**

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

[1] The shaded columns represent scoring completed on a different review template, and therefore comparisons cannot be made for these components

WCHP PIP 2: Improving the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 2: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M	M		
1b. Impacts the maximum proportion of members that is feasible		M	M		
1c. Potential for meaningful impact on member health, functional status or satisfaction		M	M		
1d. Reflects high-volume or high risk-conditions		M	M		
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M	M		
Element 1 Overall Review Determination		M	M		
Element 1 Overall Score		**100.0**	**100.0**		
Element 1 Weighted Score		**5.0**	**5.0**		
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M	M		
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M	M		
2c. Objectives align aim and goals with interventions		M	M		
Element 2 Overall Review Determination		M	M		
Element 2 Overall Score		**100.0**	**100.0**		
Element 2 Weighted Score		**5.0**	**5.0**		
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M	M		
3b. Performance indicators are measured consistently over time		M	M		

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 2: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		PM	M		
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M	M		
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		PM	M		
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		N/A	M		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline		M	M		
Element 3 Overall Review Determination		PM	M		
Element 3 Overall Score		**50.0**	**100.0**		
Element 3 Weighted Score		**7.5**	**15.0**		
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M	M		
4c. Provider input at focus groups and/or Quality Meetings		M	M		
4d. QI Process data (“5 Why’s”, fishbone diagram)		M	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M	M		
4f. Literature review		M	M		
Element 4 Overall Review Determination		M	M		
Element 4 Overall Score		**100.0**	**100.0**		

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 2: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 4 Weighted Score		**15.0**	**15.0**		
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M	M		
5b. Actions that target member, provider and MCO		M	M		
5c. New or enhanced, starting after baseline year		M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		M	M		
Element 5 Overall Review Determination		M	M		
Element 5 Overall Score		**100.0**	**100.0**		
Element 5 Weighted Score		**15.0**	**15.0**		
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M	M		
Element 6 Overall Review Determination		M	M		
Element 6 Overall Score		**100.0**	**100.0**		
Element 6 Weighted Score		**5.0**	**5.0**		
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		M	M		

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 2: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
7d. Lessons learned & follow-up activities planned as a result		M	M		
Element 7 Overall Review Determination		M	M		
Element 7 Overall Score		**100.0**	**100.0**		
Element 7 Weighted Score		**20.0**	**20.0**		
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A	N/A		
Element 8 Overall Review Determination		N/A	N/A		
Element 8 Overall Score		N/A	**N/A**		
Element 8 Weighted Score		N/A	**N/A**		
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		M	Y		
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80.0**	**80.0**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**N/A**	**N/A**
Overall Rating	**N/A**	**90.6%**	**100.0%**	**N/A**	**N/A**

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

[1] The shaded column represents scoring completed on a different review template, and therefore comparisons cannot be made for these components

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data ("5 Why's", fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	M			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 3: MCO Adolescent Risk Behaviors and Depression Collaborative	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**N/A**			
Element 7 Weighted Score	N/A	**N/A**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**52.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**87.5%**	**N/A**	**N/A**	**N/A**

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

[1] Proposal Findings were not scored.

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed		M			
1b. Impacts the maximum proportion of members that is feasible		M			
1c. Potential for meaningful impact on member health, functional status or satisfaction		M			
1d. Reflects high-volume or high risk-conditions		M			
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)		M			
Element 1 Overall Review Determination	N/A	M			
Element 1 Overall Score	N/A	**100.0**			
Element 1 Weighted Score	N/A	**5.0**			
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals		M			
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark		M			
2c. Objectives align aim and goals with interventions		M			
Element 2 Overall Review Determination	N/A	M			
Element 2 Overall Score	N/A	**100.0**			
Element 2 Weighted Score	N/A	**5.0**			
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)		M			
3b. Performance indicators are measured consistently over time		M			
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes		M			

WellCare Health Plans of New Jersey, Inc. (WCHP) PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis	IPRO Review **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined		M			
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]		M			
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.		M			
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline		M			
3h. Study design specifies data analysis procedures with a corresponding timeline		M			
Element 3 Overall Review Determination	N/A	M			
Element 3 Overall Score	N/A	**100.0**			
Element 3 Weighted Score	N/A	**15.0**			
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics		M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach		M			
4c. Provider input at focus groups and/or Quality Meetings		M			
4d. QI Process data ("5 Why's", fishbone diagram)		M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)		M			
4f. Literature review		M			
Element 4 Overall Review Determination	N/A	M			
Element 4 Overall Score	N/A	**100.0**			
Element 4 Weighted Score	N/A	**15.0**			

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis		M			
5b. Actions that target member, provider and MCO		M			
5c. New or enhanced, starting after baseline year		M			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)		PM			
Element 5 Overall Review Determination	N/A	PM			
Element 5 Overall Score	N/A	**50.0**			
Element 5 Weighted Score	N/A	**7.5**			
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals		M			
Element 6 Overall Review Determination	N/A	M			
Element 6 Overall Score	N/A	**100.0**			
Element 6 Weighted Score	N/A	**5.0**			
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)		N/A			
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan		N/A			
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.		N/A			
7d. Lessons learned & follow-up activities planned as a result		N/A			

WellCare Health Plans of New Jersey, Inc. (WCHP) **PIP 4: Early Detection and Prevention of Sepsis in the MLTSS HCBS Population at Risk for Sepsis**	**IPRO Review** **M**=Met **PM**=Partially Met **NM**=Not Met				
PIP Components and Subcomponents	Proposal Findings[1]	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Element 7 Overall Review Determination	N/A	N/A			
Element 7 Overall Score	N/A	**0**			
Element 7 Weighted Score	N/A	**0.0**			
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented		N/A			
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods		N/A			
Element 8 Overall Review Determination	N/A	N/A			
Element 8 Overall Score	N/A	N/A			
Element 8 Weighted Score	N/A	N/A			
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)		N			
	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**60.0**	**N/A**	**N/A**	**N/A**
Actual Weighted Total Score	**N/A**	**52.5**	**N/A**	**N/A**	**N/A**
Overall Rating	**N/A**	**87.5%**	**N/A**	**N/A**	**N/A**

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

[1] Proposal Findings were not scored.

WCHP Care Management Audits

WCHP 2019 Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2017 (n=100)	2018 (n=100)	% Point Change	2017 (n=20)	2018 (n=16)	% Point Change	2017 (n=26)	2018 (n=24)	% Point Change
Identification	92%	83%	-9	100%	100%	0	100%	100%	0
Outreach	97%	87%	-10	100%	97%	-3	97%	100%	3
Preventive Services	77%	100%	23	92%	100%	8	96%	95%	-1
Continuity of Care	91%	89%	-2	100%	100%	0	99%	100%	1
Coordination of Services	99%	98%	-1	98%	98%	0	100%	97%	-3

WCHP MLTSS HCBS Care Management Audit – July 1, 2018–June 30, 2019

Performance Measure	Group[1]	July 2017 – June 2018			July 2018 – June 2019			PPD[2] to Prior Year
		D	N	Rate	D	N	Rate	PPD
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.[3]	Group C	6	3	50.0%	16	14	87.5%	37.5%
	Group D	101	67	66.3%	82	77	93.9%	27.6%
	Group E							
	Total	107	70	65.4%	98	91	92.9%	27.5%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	Group C	0	0	CNC	2	2	100.0%	N/A
	Group D	2	1	50.0%	9	8	88.9%	38.9%
	Group E	16	10	62.5%	18	18	100.0%	37.5%
	Total	18	11	61.1%	29	28	96.6%	35.5%
#9a. Member's Plan of Care is amended based on change of member condition[5]	Group C	0	0	CNC	2	2	100.0%	N/A
	Group D	4	2	50.0%	1	0	0.0%	-50.0%
	Group E	3	3	100.0%	1	1	100.0%	0.0%
	Total	7	5	71.4%	4	3	75.0%	3.6%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[6]	Group C	6	5	83.3%	12	12	100.0%	16.7%
	Group D	76	74	97.4%	61	61	100.0%	2.6%
	Group E	18	18	100.0%	27	27	100.0%	0.0%
	Total	100	97	97.0%	100	100	100.0%	3.0%
#11. Plans of Care developed using "person-centered principles" [7]	Group C	6	0	0.0%	12	12	100.0%	100.0%
	Group D	76	1	1.3%	61	61	100.0%	98.7%
	Group E	18	0	0.0%	27	27	100.0%	100.0%
	Total	100	1	1.0%	100	100	100.0%	99.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[8]	Group C	3	3	100.0%	10	10	100.0%	0.0%
	Group D	76	70	92.1%	61	61	100.0%	7.9%
	Group E	18	17	94.4%	27	27	100.0%	5.6%
	Total	97	90	92.8%	98	98	100.0%	7.2%
#16. Member training on identifying/reporting critical incidents	Group C	6	6	100.0%	12	12	100.0%	0.0%
	Group D	76	73	96.1%	61	61	100.0%	3.9%
	Group E	18	18	100.0%	27	27	100.0%	0.0%
	Total	100	97	97.0%	100	100	100.0%	3.0%

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

[2]Percentage Point Difference

[3] Compliance with Performance Measure #8 was calculated using 45 calendar days to establish an initial plan of care

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

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

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

[7] In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the POC
[8]Members in CARS are excluded from this measure
CNC: Could not calculate; N/A: Not applicable

WCHP Nursing Facility Audit: Plan of Care for Institutional Settings – July 1, 2017-June 30, 2018

Tables A-E: Plan of Care for Institutional Settings

Table A

Facility and MCO Plan of Care	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period	58	100	58%	87	100	87%	29%
Documented Review of the Facility Plan of Care by the Care Manager	26	100	26%	87	100	87%	61%
MLTSS Plan of Care on file includes information from the Facility Plan of Care	20	58	34%	31	31	100%	66%

Table B

Plan of Care Development	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Completion of Initial Plan of Care – Member had a completed, signed initial plan of care on file that was provided to the Member and/or representative within 45 calendar days of enrollment into the MLTSS program (for Members newly enrolled in managed care and newly eligible for MLTSS during the review period)	6	33	18%	12	44	27%	9%
Agreement/Disagreement statements from the Plan(s) of Care on file during the review period were reviewed with the Member and/or representative at each visit	27	100	27%	30	100	30%	3%
Written Member Goals include all 5 Components; (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 – reviewed at each visit and documented progress)	26	100	26%	32	100	32%	6%
Plan of Care addresses formal and informal services. Member was given the opportunity to express his/her needs or preferences, and these needs or preferences were acknowledged and addressed in the Plan of Care, including the coordination of formal and informal services	60	100	60%	30	100	30%	-30%
Plan of Care developed with person-centered principles. POC documentation reflected a member-centric approach demonstrating the involvement of the Member and/or representative in the development of his/her goals	32	100	32%	29	100	29%	-3%
Member and/or representative participated in the development of goals	32	100	32%	29	100	29%	-3%

Table C

Transition Planning	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was identified for transfer to HCBS and was offered options, including transfer to the community	94	100	94%	86	100	86%	-8%
Evidence of the **Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)	7	100	7%	75	100	75%	68%
Timely Onsite Review of Member Placement and Services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)	19	100	19%	28	100	28%	9%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable)	80	85	94%	90	93	97%	3%
Members requiring coordination of care had **coordination of care** by the Care Manager	5	6	83%	81	97	84%	1%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission	0	0	N/A	73	73	100%	CNC

N/A: Indicates a denominator of 0

CNC: Could not calculate

Table D

Reassessment of the POC and Critical Incident Reporting	Review Period (July 1, 2016- June 30, 2017)			Review Period (July 1, 2017- June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Updated Plan of Care for a Significant Change. For any significant change in member condition, Member's plan of care was updated, reviewed and signed by the Member and/or representative, and a copy was provided to the Member and/or representative	0	8	0%	0	2	0%	0%
Member had a **New Jersey Choice Assessment completed** during the review period	88	100	88%	74	100	74%	-14%
NJCA completed for Members newly enrolled in care and newly eligible for MLTSS during the review period	33	34	97%	32	36	89%	-8%
NJCA completed for Members enrolled in MLTSS with the MCO prior to the review period	55	66	83%	42	64	66%	-17%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation	0	100	0%	81	100	81%	81%

Table E

PASRR Communication for Transitions to/from NF/SCNF	Review Period (July 1, 2016-June 30, 2017)			Review Period (July 1, 2017-June 30, 2018)			Percentage Point Change
	N	D	Rate	N	D	Rate	
Member was admitted to a NF/SCNF prior to the review period	94 Members (94%)			89 Members (89%)			
Member was admitted to an NF/SCNF during the review period	6 members (6%)			11 members (11%)			
Care Manager completed or confirmed PASRR Level I and Level II, if applicable prior to Transfer to NF/SCNF	5	6	83%	11	11	100%	17%
Communication of PASRR Level I to OCCO through an NJCA by Care Manager	5	6[1]	83%[1]	11	11	100%	17%
Communication of PASRR Level II to OCCO through an NJCA by Care Manager	0	0	N/A	0	0	N/A	CNC
Members who had PASSR Level II forms indicating a need for **Specialized Services Setting was coordinated appropriately with DDD/DMHAS**	0	0	N/A	0	0	N/A	CNC

[1]Denominator and rate for **Communication of PASRR Level I** to OCCO through an NJCA by Care Manager for the review period of July 1, 2016-June 30, 2017 have been updated. During comparative analysis of the current review period to the prior period, an error was identified in the prior rate. This report accurately reflects the numerators, denominators, rates, and PPD for 2017 and 2018.
N/A: Indicates a denominator of 0
CNC: Could not calculate

WCHP NF/SCNF Members Transferred to HCBS – July 1, 2017–June 30, 2018

NF/SCNF Member Transferred to HCBS	Groups 2, 4		
	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF	0	0	**N/A**
Cost Effectiveness Evaluation was completed for the Member prior to discharge from a NF/SCNF	0	0	**N/A**
Plan of Care Updated Prior to Discharge from a Facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community	0	0	**N/A**
Person-centered transition Plan of Care on file for the Member	0	0	**N/A**
Participation in an IDT related to Transition. Care Manager participated in the coordination of an Interdisciplinary Team Meeting (IDT) related to transition planning	0	0	**N/A**
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer	0	0	**N/A**
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care	0	0	**N/A**
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored

WCHP HCBS Members Transferred to a NF/SCNF – July 1, 2017–June 30, 2018

HCBS Members Transferred to a NF/SCNF	Groups 3, 4		
	N	D	Rate
Care Manager presented and disclosed service delivery options with the Member, and **provided the Member with the opportunity to retain HCBS with a potential Risk Management Agreement** (not required for HCBS Members who were hospitalized and discharged directly to a NF/SCNF as a result of their condition and remained there)	0	0	**N/A**
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement**	0	0	**N/A**

N/A: Indicates a denominator of 0

Reviews of this population are optional and not scored