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New Jersey Department of Human Services
Division of Medical Assistance and Health Services
CORE MEDICAID and MLTSS
External Quality Review
Annual Technical Report
Review Period: January 1, 2023–December 31, 2023
(2023–2024 Reporting Cycle)

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I. Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), contracted with IPRO, an EQRO, to conduct the 2023 EQR activities (reporting cycle 2023-2024) for five MCOs contracted to furnish Medicaid services in the state. During the period under review, January 1, 2023–December 31, 2023, DMAHS's participating NJ FamilyCare Managed Care MCOs included 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) doing business as (d.b.a.) Fidelis Care (FC/WCHP). As per DMAHS, enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP for Core Medicaid and Managed Long-Term Services and Supports (MLTSS) was 2,088,187 as of 12/31/2023. This report presents aggregate and MCO-level results of these EQR activities for ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP. *NOTE: WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective August 1, 2023. For the purposes of this report, this MCO will be designated as FC/WCHP. Additionally, Amerigroup New Jersey, Inc. began doing business as Wellpoint New Jersey, Inc. as of January 1, 2024. For the purposes of this report, the MCO will be designated as AGNJ.*

Scope of External Quality Review Activities Conducted

This EQR technical report focuses on the three mandatory and five optional EQR activities that were conducted. EQR activities conducted from January 2023–December 2023 included annual assessment of MCO operations, performance measure (PM) validation, validation of performance improvement projects (PIPs), focus studies, which include Core Medicaid care management (CM) audits, and MLTSS CM audits, encounter data validation, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and calculation of additional PMs.

It should be noted that validation of network adequacy (Protocol 4) was not conducted at the state's discretion, as CMS had not updated the activity protocols for this activity until the February 2023 CMS *External Quality Review (EQR) Protocols* were published.[1] Validation of Assist with the Quality Rating of Medicaid MCOs (Protocol 10) was not conducted by IPRO during this review period. CMS has not published an official protocol for this activity. The updated protocols stated that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR § 438.358 Activities related to external quality review* (b)(1), these activities are:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Optional Protocol 5:* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality of Care Surveys –** In 2023, two satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.
- ***CMS Optional Protocol 7:* Calculation of Additional Performance Measures –** This activity specifies that the external quality review organization (EQRO) may calculate performance measures in addition to those specified by the state for inclusion in MCOs' QAPI programs.
- ***CMS Optional Protocol 8:* Implementation of Additional Performance Improvement Projects –** This activity validates that additional MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality –** This activity conducts clinical and non-clinical focus studies to assess quality of care at a point in time.

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

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

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

While the *CMS External Quality Review (EQR) Protocols* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and

[1] Centers for Medicare and Medicaid (CMS) (2023). *CMS external quality review (EQR) protocols*. https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf.

Information Set (HEDIS®) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of the MCOs' HEDIS final audit reports (FARs) are in **Section V: Validation of Performance Measures**. A full ISCA was conducted with each NJ MCO in 2020. In May 2024, another full ISCA will be conducted across all five NJ MCOs.

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2023–2024 EQR activity findings to assess the performance of NJ Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

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

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted from January 1, 2023, through December 31, 2023, demonstrated that DMAHS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members. The opportunities for improvement and recommendations relating to quality of, timeliness of, and access to care are outlined here and detailed in each corresponding section of this report.

Validation of Performance Improvement Projects

For January 2023–December 2023, this annual technical report (ATR) includes IPRO's evaluation of the April 2023 PIP updates, August 2023 PIP report submissions. In addition, IPRO reviewed one Core Medicaid PIP Proposal on Member Grievances and provided feedback and guidance to all five MCOs. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Full validation results for the Core Medicaid and MLTSS 2023 PIPs are described in **Section III: Validation of Performance Improvement Projects**.

Core Medicaid:

The following two (2) Core Medicaid PIPs were conducted by the MCOs during the ATR review period. One Core Medicaid PIP is clinical, and one PIP is non-clinical.

1. Access and Availability of PCP Services (Non-Clinical PIP) – (ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP) (August Project Status Reports Submission – Project Year 2 and Sustainability Update) Note: ABHNJ is one year behind in the PIP reporting cycle.
2. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – (ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP) – (August Project Status Reports Submission – Project Year 1 and Project Year 2 Update).

One PIP Proposal (PIP to be implemented in January 2024) on Member Grievances was developed by each MCO during the ATR review period.

MLTSS:

The following MLTSS PIP was conducted by the MCOs during the ATR review period.

All five (5) MCOs (ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP) are engaged in an MLTSS PIP for the topic regarding Improving Coordination of Care Following Up Mental Health Hospitalization (August – Project Status Reports Submission – Project Year 1 and Project Year 2 Update).

Review of Compliance with Medicaid and CHIP Managed Care Regulations

The EQRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing Medicaid managed care (MMC) programs, as detailed in the CFR. The annual assessment of MCO operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. Children's Health Insurance Program (CHIP) is included in the Medicaid data being presented.

In 2023, the Annual Assessment audits were conducted remotely. For the review period July 1, 2022–June 30, 2023, ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP scored above NJ's minimum threshold of 85%. In 2023, the average compliance score for seven standards (Quality Management, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, Credentialing and Re-Credentialing, and Administration and Operations) showed increases ranging from 1 to 4 percentage points. In 2023, seven standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, and Administration and Operations) had an average score of 100%. Average compliance for two standards (Quality Assessment and Performance Improvement [QAPI] and Efforts to Reduce Healthcare Disparities) remained the same at 100% from 2022 to 2023. Four standards (Access, Satisfaction, Utilization Management and Management Information Systems) decreased 1 to 10 percentage points from 2022 to 2023. Access had the lowest average compliance score at 69%. One new category (Member Disenrollment) was added in 2023 for review, therefore, comparisons to last year are not applicable. Findings from this review can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of each MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these fourteen (14) standards be evaluated. Of the 228 elements reviewed during the Annual Assessment, 94 crosswalk to the CMS QAPI Standards. The crosswalk of the individual elements reviewed during the Annual Assessment to the CMS QAPI Standards can be found in **Section IV: Review of Compliance with Medicaid and CHIP Managed Care Regulations**.

Validation of Performance Measures

Information Systems Capabilities Assessment

In 2016, CMS issued the Medicaid and CHIP Final Rule. In accordance with the 2016 Final Rule, CMS updated the EQR protocols, which were released in 2019. The updated protocols indicated that an ISCA is a mandatory component of the EQR for Protocols 1 (Validation of Performance Improvement Projects), 2 (Validation of Performance Measures), 3 (Review of Compliance with Medicaid and CHIP Managed Care Regulations), and 4 (Validation of Network Adequacy). The five Medicaid MCOs in NJ use HEDIS-certified software and submit audited HEDIS results to NJ. However, some measures, such as non-HEDIS Core set measures, measures associated with MLTSS, and NJ-specific measures for Medicaid, are produced outside of the HEDIS audit. While CMS has clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA, DMAHS determined that all five MCOs should undergo an ISCA as part of the scheduled annual assessment of compliance with MMC regulations. The ISCAs were conducted by IPRO in 2020.

The assessment covered the following areas:

- Data Integration and Systems Architecture
- Claims/Encounter Data Systems and Processes
- Membership Data Systems and Processes
- Provider Data Systems and Processes

- Oversight of Contracted Vendors
- Supplemental Databases
- Grievance Systems

Separate from the ISCA, all five MCOs undergo a systems review annually as part of their HEDIS audit by an NCQA-licensed organization. IPRO reviews these results annually. Details of this review can be found in **Section V: Validation of Performance Measures**. In addition to the annual review of information systems (IS) that is conducted during the annual HEDIS review for each MCO in NJ, the annual assessment review conducted by IPRO for each organization includes review of 18 separate IS elements. Review of the IS elements includes live demonstration of systems. In May 2024, a full ISCA will be conducted across all five NJ MCOs. Final report findings will be presented in the next ATR in 2025.

MY 2022 New Jersey HEDIS Performance Measures

(NCQA National Medicaid Benchmarks are referenced in this section, unless stated otherwise.)

The NJ FamilyCare Managed Care Contract article 4.6.2.P requires NJ FamilyCare MCOs to report annually on HEDIS PMs 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 FAR prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. CHIP is included in the Medicaid data being presented.

Notable HEDIS Measure Changes from MY 2021 to MY 2022

1. For measurement year (MY) 2022, the eligible population for the AMB measure is the reported member years. For AMB measure rates, the eligible population and average were multiplied by 12 as member months changed to member years in MY 2022.
2. For MY 2022, NCQA revised the FUA terminology from "alcohol or other drug abuse or dependence (AOD)" to "substance use" or "substance use disorder (SUD)."
3. For MY 2022, NCQA advised the indicators in the IET measure underwent major changes and are not comparable to the parent indicators in MY 2021. New indicator keys were issued and will not provide links back to the original IET indicators.
4. In MY 2022, NCQA added new data element tables for race and ethnicity stratification reporting for the following five measures: Child and Adolescent Well-Care Visits (WCV), Prenatal and Postpartum Care (PPC), Controlling High Blood Pressure (CBP), Hemoglobin A1c Control for Patients with Diabetes - HbA1c Control (<8%) (HBD), and Colorectal Cancer Screening (COL).

For MY 2022, HBD, EED, and BPD measures resulted from the separation of indicators that replace the former Comprehensive Diabetes Care sub-measures. MY 2021 CDC indicators were used to compare values for the prior year.

New Jersey Medicaid Weighted Average Year-Over-Year Performance for HEDIS Measures

Overall, most measures remained constant from MY 2021 to MY 2022 (< 5 percentage point change). Significant improvement (≥ 5 percentage point change) in performance from MY 2021 to MY 2022 were noted for one or more rates of Childhood Immunization (CIS), Asthma Medication Ratio (AMR), Appropriate Testing for Pharyngitis (CWP), Kidney Health Evaluation for Patients with Diabetes (KED), Follow-up After Emergency Department Visit for Mental Illness (FUM), and Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP). Significant declines (≥ 5 percentage point change) in performance from MY 2021 to MY 2022 were noted for one or more rates for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC), Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB), Appropriate Treatment for Upper Respiratory Infection (URI), and Follow-up After Hospitalization for Mental Illness.

MY 2022 New Jersey State-Specific Performance Measures and Core Set Measures

Measures reported for MY 2022 by the MCOs can be categorized as follows:

There are two required NJ State-Specific PMs:

1. Preventive Dental Visit (NJD)
2. Multiple Lead Testing in Children through 26 months of age (MLT)

There are seven Child Core Set measures:

1. Developmental Screening in The First Three Years of Life (DEV-CH)
2. Contraceptive Care Postpartum Women ages 15-20 (CCP-CH)
3. Contraceptive Care All Women ages 15-20 (CCW-CH)
4. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
5. Preventive Oral Evaluation, Dental Services (OEV-CH)
6. Topical Fluoride for Children (TFL-CH)
7. Sealant Receipt on Permanent First Molars (SFM-CH)

There are six Adult Core Set measures:

1. Diabetes Short-Term Complications Admission Rate (PQI01-AD)
2. Contraceptive Care Postpartum Women ages 21-44 (CCP-AD)
3. Contraceptive Care All Women ages 21-44 (CCW-AD)
4. Screening for Depression and Follow-up Plan: Ages 18 to 64 and Ages 65 and Older (CDF-AD)
5. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
6. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

The changes from MY 2021 to MY 2022 are:

1. The following measures were added:
    a. Preventive Oral Evaluation, Dental Services (OEV-CH)
    b. Topical Fluoride for Children (TFL-CH)
    c. Sealant Receipt on Permanent First Molars (SFM-CH)
    d. Screening for Depression and Follow-up Plan: Ages 18 to 64 and Ages 65 and Older (CDF-AD)
    e. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)
    f. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
2. Contraceptive Care – Postpartum Women Ages 15-20 and Ages 21-44: the check for methods of contraception was updated to within 3 and 90 days of delivery.

Performance on the Preventive Dental measures remained consistent with MY 2021 for all MCOs except ABHNJ, which reported significant declines. All five MCOs had an increase in performance for the Preventive Dental measure. Overall performance for all the MCOs remained consistent with MY 2021 for Multiple Lead Testing in Children - Screening between 9 months and 18 months measure, except for HNJH, which reported a significant increase. Admission rates for Diabetes Short-Term complications remained consistent except for HNJH, which reported a significant decrease (a decrease is indicative of an improvement). Details of these results can be found in **Section V: Validation of Performance Measures**.

MLTSS Performance Measure Validation

Waiver Year Ending (WYE) 2021 refers to the period July 1, 2020, through June 30, 2021
WYE 2022 refers to the period July 1, 2021, through June 30, 2022.
WYE 2023 refers to the period July 1, 2022, through June 30, 2023.

Activities conducted during CY 2023 included validation of measures for the three (3) WYE periods, due to the lag time for reporting some claims based and HEDIS based measures and updating and establishing specifications for all MLTSS PMs for WYE 2024.

All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO, PM #04 is reported on a monthly basis. Four HEDIS measures and one MLTSS-specific measure (PM #47) are reported annually. All other PMs are reported on a quarterly and annual cycle. PM #20a was retired in 2021.In addition to annual validation of all PMs, IPRO monitored all ongoing reporting to the state on a quarterly basis. Note: In the course of validating WYE 2022 PMs, an issue was identified with population definition for FC/WCHP. This issue impacted both WYE 2022 rates and previously submitted rates for WYE 2021. Final validation of WYE 2022 and restatement of rates for WYE 2021 is still ongoing. A list of all MLTSS performance measures validated in WYE 2022 and WYE 2023 can be found in **Section V: Validation of Performance Measures.**

WYE 2021 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 MLTSS Home and Community-Based Services (HCBS) are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: Adult Family Care, Assisted Living Services/Programs, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly Monitoring, PCA/Home Based Supportive Care, PERS Monitoring, and Private Duty Nursing.

Only MLTSS services that occurred between July 1, 2020, and June 30, 2021, were evaluated. For the measurement period July 2020 to June 2021, Members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2020, and June 30, 2021. Details of these results can be found in **Section V: Validation of Performance Measures.**

WYE 2022 MLTSS Performance Measure #13

Performance Measure #13 (PM #13) evaluates delivery of MLTSS services to members compared with services identified in the POC. This measure ensures MLTSS HCBS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: 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, and Private Duty Nursing. In 2023, as directed by DMAHS, IPRO added the Compliance Score Ranges for the delivery of MLTSS Services.

Only MLTSS services that occurred between August 15, 2021, and June 30, 2022, were evaluated. Plans of Care that only contained information regarding the Members' self-directed services (e.g., Personal Preference Program) or TBI-specific services were excluded. If the POC indicated that a service was to begin before the measurement period, the begin date of service was set at August 15, 2021. If a service extended beyond the measurement period, the end date of service was set at June 30, 2022. Details of these results can be found in **Section V: Validation of Performance Measures.**

2022 MLTSS Service Delivery Project- Phase II

The purpose of the MLTSS Service Delivery Project is to evaluate compliance of the delivery of four specific MLTSS services, in accordance with the MLTSS members' POCs for members of HCBS for NJ Medicaid MCOs. The four types of services include: Home Delivered Meals (HDM), Medical Day Care (MDC), Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). Evaluation of POC compliance with service delivery is based on type, scope, amount, frequency, and duration of service.

In addition to evaluating delivery of services in accordance with the POC, MCOs were evaluated against the following PMs: PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS HCBS; PM #10: Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment (NJCA); and PM #11: Plans of Care developed using "person-centered principles".

In 2022, the MLTSS Service Delivery project was based on the measurement period January 1, 2020, through December 31, 2020. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 and was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. IPRO developed an algorithm, to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of CM notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. POCs that contained no information about the MLTSS services were excluded from the evaluation of the MLTSS services, but were included for scoring of PM #8, PM #10, and PM #11. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the Primary Source Verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems.

Each MCO reviewed and approved the rates for the 2022 MLTSS Service Delivery Project. Final results for this project by MCO can be found in **Section V: Validation of Performance Measures**.

Quality of Care Surveys

Member Satisfaction – 2023 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 FC/WCHP. Aggregate reports were produced for the adult and child surveys. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2022, through December 31, 2022, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey. Details on these surveys can be found in **Section VI: Administration or Validation of Quality of Care Surveys – CAHPS Member Experience Survey**.

Care Management Audits

2023 Core Medicaid Care Management Audits

IPRO undertook Core Medicaid CM Audits of ABHNJ, AGNJ, FC/WCHP, HNJH, and UHCCP. The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM programs and CM services provided to 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 the General Population (GP).

In 2023, IPRO and the Office of Quality Assurance (OQA) collaborated on revising the *NJ EQRO MCO Care Management Audit Tool* to improve and refine the audit process.

Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for the GP, DDD, and DCP&P populations. For the GP population, an additional metric, Identification, was also evaluated.

The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, up to 300 DDD, DCP&P and GP charts are reviewed for each MCO. The actual number of charts reviewed depended on the population size that meets the sample criteria for audit. In addition to the Core Medicaid CM chart review audit, in 2023, the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed *the Core Medicaid Care Management Document Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The Annual Assessment of the Care Management and Continuity of Care standard covered the period from January 1, 2022, to December 31, 2022. There were 30 elements in this review based on contractual provisions, which are subject to review annually. Remote interviews with the MCOs were held with key MCO staff in May 2023. Overall compliance scores for the five MCOs ranged from 70% to 80% in 2023. Results of this review can be found in **Section VII: Care Management Audits**.

2023 MLTSS HCBS Care Management Audits

The purpose of the MLTSS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special-needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following state guidance, MCOs expanded Face-to-Face visits to all MLTSS members and resumption of the NJCA. The 2019 novel coronavirus (COVID-19) pandemic flexibilities were in place related to specific CM activities to allow care managers to conduct telephonic monitoring if the member refused an in-person visit, including the NJCA Face-to-Face visit, with evidence of documented refusals in the member file. In addition, the NJ DHS, Division of Aging Services, Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting was in effect during this review period. The populations included in this audit were members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS) for at least six (6) consecutive months within the review period July 1, 2022, to June 30, 2023.

Annually, DMAHS evaluates MCO performance against these requirements through its EQRO contractor. The results of these audits are used to improve MCO performance. Results of this review can be found in **Section VII: Care Management Audits.**

2022 Return to Field MLTSS Home and Community Based Setting (HCBS) Focus Study

In 2022, at the request of DMAHS, in conjunction with the 2022 MLTSS HCBS audit, IPRO developed a focus study on the return to field for the MLTSS and HCBS population to evaluate the MCO's compliance with the DMAHS "Return to Field Guidance" dated August 11, 2021. Due to the COVID-19 pandemic, Face-to-Face visits

were suspended for HCBS members in March 2020. On August 15, 2021, MCOs were mandated to resume certain in-person CM activities. This focus study evaluated MCO compliance with the "MCO CM Visit Guidance for Phase 1: Face-to-Face Visits for MLTSS High-Risk Members" for the time period 8/15/2021 through 11/15/2021. Study findings can be found in **Section VII: Care Management Audits.**

2023 MLTSS Nursing Facility (NF) Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special-needs members who met MLTSS eligibility requirements as specified in Article 9 are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in an NF/SCNF for at least 6 consecutive months within the review period. Typically, the review period for the annual NF audit is from July 1st through June 30th. Due to the COVID-19 pandemic, the prior review period was from January 1, 2021, through August 14, 2021, during which Face-to-Face visits were suspended and access to NFs was restricted. The review period for this audit was August 15, 2021, through August 31, 2022, during which DMAHS issued the *MCO Care Management Visit Guidance*. Effective November 16, 2021, MCO care managers were to expand Face-to-Face visits to all MLTSS members and resume completion of the NJCA. The COVID-19 flexibilities were in place related to specific CM activities, allowing telephonic visits for members who refused an in-person visit, and for NFs with visitation protocols restricting care manager access. In addition to the CM audit, MLTSS PMs #8, #9, #9a, #11, and #16 were calculated.

Annually, DMAHS evaluates MCO performance against these requirements through its EQRO contractor. The results of these audits are used to improve MCO performance. Results of this review can be found in **Section VII: Care Management Audits.**

Focus Studies

2022 Prenatal and Postpartum Care Focus Study

In 2022, at the request of DMAHS, IPRO developed a clinical focus study on prenatal and postpartum care. This was a descriptive study, which aimed to identify sociodemographic disparities in the access and availability of prenatal and postpartum care among Medicaid beneficiaries in NJ as measured by the HEDIS PPC measure. Study findings can be found in **Section VIII: Focus Studies of Health Care Quality**.

Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the state Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2023, IPRO continues to monitor encounter data submissions and patterns. Study findings can be found in **Section IX: Encounter Data Validation**.

Conclusion and MCO Recommendations

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

II. New Jersey Medicaid Managed Care Program

Managed Care in New Jersey

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. Per DMAHS, as of December 2023 there were approximately 2,021,931 individuals enrolled in Medicaid Managed Care (MMC and the number decreased from 2,158,966 in December 2022 (**Table 1**). Of the 2,021,931 individuals enrolled in MMC, 66,256 were receiving MLTSS services as of December 2023. More than 96% of managed care eligible beneficiaries receive services through the managed care program (data not shown).

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

This renewal is intended to modify and extend this demonstration for an additional 5 years. A copy of the 1115 Demonstration Renewal Draft Proposal and accompanying presentation was posted on the DMAHS website for public review and comment.

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

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in December 2022–December 2023. **Table 1** presents respective enrollment figures in December 2022 and December 2023.

Table 1: December 2022–December 2023 Medicaid MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2022	December 2023	December 2022	December 2023
Aetna Better Health of New Jersey	ABHNJ	139,597	130,429	5,963	6,079
Amerigroup New Jersey, Inc.	AGNJ	266,927	242,271	10,978	10,757
Horizon NJ Health	HNJH	1,218,011	1,148,311	22,684	22,674
UnitedHealthcare Community Plan	UHCCP	420,685	398,784	12,561	13,017
Fidelis Care/WellCare Health Plans of New Jersey, Inc.	FC/WCHP	113,746	102,136	13,675	13,729
	Total	2,158,966	2,021,931	65,861	66,256

[1] Managed Long-Term Services and Supports (MLTSS) members are included in the December 2022–2023 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 2022 and December 2023 in relation to the entire NJ MMC population.

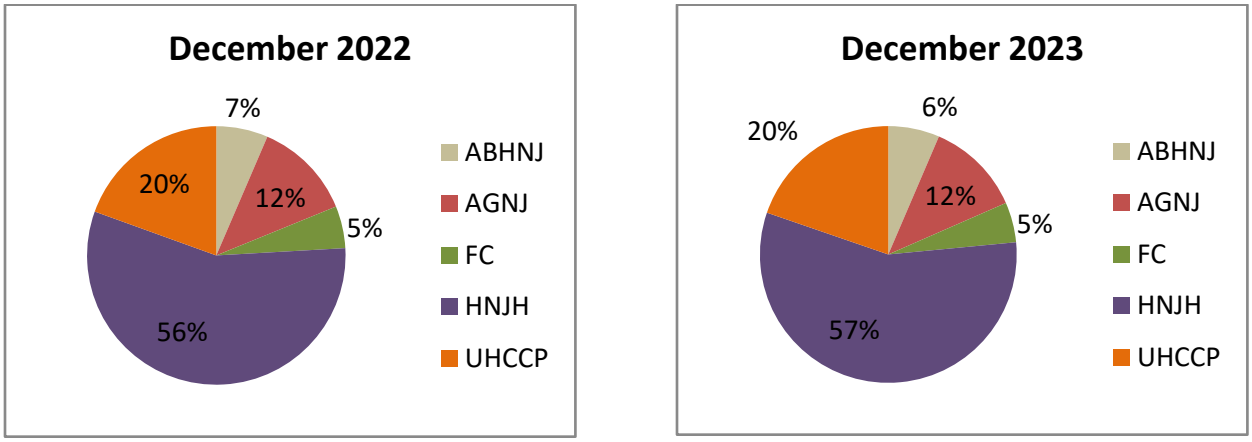

Figure 1: December 2022 – December 2023 Medicaid Managed Care Enrollment by MCO
Enrollment in MMC for each MCO reported as of December 2022 (left panel) and December 2023 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (gray); AGNJ: Amerigroup New Jersey, Inc. (red); FC: Fidelis Care/WellCare Health Plans of New Jersey, Inc. (green); HNJH: Horizon NJ Health (purple); UHCCP: UnitedHealthcare Community Plan (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: 2023 EQR Activities by MCO

MCO	EQR Activity								
	Annual Assessment of MCO Operations	PMs	Core Medicaid/ MLTSS PIPs	Focus Quality Studies	CAHPS Surveys	Core Medicaid CM Audits	MLTSS HCBS CM Audits	MLTSS NF CM Audits	ISCA Assessments[1]
ABHNJ	√	√	√	√	√	√	√	√	√
AGNJ	√	√	√	√	√	√	√	√	√
HNJH	√	√	√	√	√	√	√	√	√
UHCCP	√	√	√	√	√	√	√	√	√
FC/WCHP	√	√	√	√	√	√	√	√	√

[1] A full ISCA was conducted in 2020. Healthcare Effectiveness Data and Information Set (HEDIS) information systems (IS) assessments are conducted every year including 2023.
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; ISCA: Information Systems Capabilities Assessment.

New Jersey – 2023 State Initiatives

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

This chapter provides information on initiatives that DMAHS is undertaking to improve quality of care and information technology. DMAHS has been active in the following State Initiatives: 1115 Renewal Proposal; Federal Medical Assistance Percentage (FMAP) for Medicaid Home and Community-Based Services (HCBS); Electronic Visit Verification (EVV); Health Information Technology (HIT) and the Medicaid Enterprise System; Quality Improvement Program-New Jersey (QIP-NJ); Maternal/Child Health; Medicaid Innovator Accelerator Program (IAP) Value Based Purchasing (VBP): Home and Community Based Services (HCBS); and Expansion of NJ WorkAbility.

1115 Renewal Proposal

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

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

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

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

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

- **Serve our communities the best way possible**:
  - Address known gaps and improve quality of care in maternal and child health.
  - Expand health equity analyses to support better access and outcomes for communities of color and people with disabilities, while also seeking to improve the experience of other historically marginalized groups where data may not be available for analysis (e.g., LGBTQ identity).

New Jersey continues to work with our federal partners at CMS to implement elements of the Demonstration throughout the renewal period.

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

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

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

This spending plan lasts until March of 2025, and through the quarterly update process, New Jersey continues to work with CMS to receive approval of outstanding activities, implement already approved activities, and update budget assumptions.

Electronic Visit Verification
Electronic Visit Verification Section 12006(a) of the 21st Century Cures Act (Cures Act) mandates that states implement electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS). In compliance with this mandate, DMAHS' EVV aggregation vendor provides a centralized web-based EVV system using the Open Vendor Model based on stakeholder feedback and preferences.

In accordance with the Cures Act, PCS and HHCS utilize EVV to capture required data elements. New Jersey's EVV system assures services are prior authorized and delivered by the provider according to members' assessed needs. New Jersey utilizes the data to monitor and ensure that applicable services are EVV-compliant. Additionally, the aggregated data are used for reporting quarterly Key Performance Indicators (KPIs) to the Centers for Medicare and Medicaid Services (CMS).

Collaboration, training, and communication with stakeholders, providers, members, and families continue to ensure compliance, member-focused care, and high-quality service delivery remain the focus of New Jersey's EVV program.

Health Information Technology and the Medicaid Enterprise System

The Division of Medical Assistance & Health Services (DMAHS) continues to put health information technology (HIT) at the forefront, supporting initiatives that promote interoperability to reduce healthcare costs, and improve care coordination and administrative efficiencies. The COVID-19 public health emergency (PHE) has cast a spotlight on the importance of interoperability and health information sharing. While the pandemic has also exposed the gaps between disparate health systems, it has also presented several areas of opportunity to grow the health information technology infrastructure of the State Health Information Exchange (HIE) for better care coordination and improved patient health outcomes. In addition, DMAHS had continued to leverage HIT in the subsequent unwinding effort from continuous Medicaid enrollment.

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

In 2023, DMAHS MES efforts was able to maintain operational stability and deliver on key program and policy initiatives listed below:

- Cover All Kids: As of January 1, 2023, the legacy MMIS began to support the initiative to provide coverage for all income eligible kids regardless of immigration status. This provides improved access to primary and preventive services to promote better health outcomes and lower overall costs of care.
- Workability: As of April 1, 2023, the legacy MMIS supported the initial roll-out of the Workability program that offers people with disabilities who are working and whose income would make them ineligible for Medicaid the opportunity to receive full Medicaid coverage.
- Post-Partum Extension: As of February 2023, the legacy MMIS, in conjunction with the Integrated Eligibility System, extended coverage for post-partum individuals to a full year. This effort assists to improve maternal health and coverage stability and to help address racial disparities in maternal health.
- Naloxone 365: As of January 1, 2023, Naloxone could be obtained anonymously and for free by New Jerseyans 14 years of age and older. New Jersey is the first state in the nation to implement this type of program, which improves the availability of Naloxone to facilitate rapid intervention and save lives. All FDA approved 4 mg Naloxone nasal spray are covered. Claims are paying and volume is increasing as we build awareness.

Medicaid Management Information System (MMIS)

DMAHS continues with modernization initiatives for the MMIS (MMIS-M), which is a key component in the operation of DMAHS programs for providing comprehensive health coverage to over 2 million New Jersey residents. While the PHE along with preparations for the PHE unwinding were a major focus in FFY 2023, DMAHS made strides in MMIS modernization efforts and was able to:

- Advance Provider Module procurement efforts via the National Association of State Procurement Officials (NASPO) ValuePoint Cooperative Purchasing program with one round of vendor virtual demonstration completed and a second one underway as part of the down-selection process that will culminate in an award in early 2024;
- Finalize the components for the Pilot Integration Platform and the scope for the legacy MMIS vendor integration requirements;
- Deploy the Patient Access Application Programming Interface (API) for the Fee-for-Service (FFS) Program;
- Achieve and maintain "Blue Status" using the Outcomes Based Assessment (OBA) for the Transformed Medicaid Statistical Information System {T-MSIS) which indicates that New Jersey has met OBA targets and passed on critical priority, high priority, and expenditures;
- Complete onboarding of Berry Dunn to provide project management support services and facilitate organizational readiness; and
- Deploy JIRA, an issue and project-tracking tool, to support agile project management as an enterprise tool.

DMAHS has also prioritized data completeness and quality to support TMSIS reporting. To this end, a concerted effort involving collaboration among cross-functional disciplines from policy, technical, and operations units has effectively addressed outstanding issues identified from the Outcomes Based Assessment (OBA). DMAHS will continue to refine its MMIS modernization roadmap to ensure alignment with program goals and priorities and utilize an outcomes-focused investment strategy.

NJ FamilyCare Integrated Eligibility System

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

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

In 2023, NJ FamilyCare IES made system enhancements in support of policy updates for the MES defined above to address beneficiaries' needs, while at the same time prepared for accommodating the unwind from the COVID-19 public health emergency continuous eligibility. Some of these enhancements and module deployment include:

- Upgrades to processing of electronic renewal applications which allows applicants to submit and renew application online;
- Enhancements to ex-parte application processing to improve procedural renewals and minimize procedural terminations;
- Expanding automatic upload functionality to the mainframe Medicaid Eligibility System to streamline county eligibility determination;
- Enhancements to support seamless transition of eligible members to the Medicare Savings Program administered by New Jersey's Division of Aging Services.

These NJ FamilyCare IES functionalities will only continue to improve eligibility determination processing time in order to provide for the healthcare needs of the most vulnerable beneficiaries in the State. In the coming year, New Jersey Eligibility and Enrollment effort will continue to focus on several high priority projects including the PHE unwind activities. The goal is to ensure that ~2.1 million beneficiaries are properly renewed or referred to make certain that health coverage is made available to those in need of service.

Health Information Technology and the New Jersey Health Information Network

The HITECH/ Medicaid Promoting Interoperability Programs administered by DMAHS (from 2011 through 2021) has catalyzed health information technology adoption in the healthcare settings across New Jersey. Despite the complex demands of the program, professional practices and hospitals statewide have implemented certified Electronic Health Record technology and more information is being shared electronically. New Jersey Health Information Network (NJHIN), the State health information exchange (HIE) infrastructure, has also been an integral part of the HITECH program, with the goal to advance interoperability and improve care coordination. DMAHS leveraged CMS funding to support the development of the NJHIN and associated HIE use cases. In collaboration with the New Jersey Department of Health, the state entity that administers the NJHIN, several HIT programs and initiatives had been successfully implemented:

- Successful certification of the NJHIN under the CMS Streamlined Modular Certification to continue receiving operational funding in the transition from HITECH to Medicaid Enterprise Systems (MES).
- Provider-based outreach utilizing the NJHIN in support of continuous Medicaid enrollment unwinding efforts;
- Use of NJHIN event notification data (Admission, Discharge, and Transfer) for the Perinatal Episode of Care value-based payment pilot program;
- Substance Use Disorder Promoting Interoperability Program (SUD PIP) to promote the adoption of Health Information Technology among the SUD providers in addressing the opioid crisis.

DMAHS is also assisting the Division of Consumer Affairs (DCA) to certify the New Jersey Prescription Monitoring Program (NJPMP) for the continued operations funding as part of the Medicaid Enterprise. The NJPMP is an important tool in addressing the opioid crisis by halting the abuse and diversion of controlled prescription medications.

New Jersey Medicaid remains committed to placing health information technology at the forefront to enhance the healthcare quality for the residents of New Jersey. As we continue to make strides in health information technology projects, the key accomplishments to highlight from last year showcases New Jersey's steadfast dedication to advancing interoperability capabilities enabling providers to access clinical health data and reducing administrative burden.

Quality Improvement Program– New Jersey (QIP-NJ)
In conjunction with DMAHS, the Department of Health continues its administration of the QIP-NJ program, a hospital pay-for-performance initiative that launched in 2021. QIP-NJ has a dual focus of quality improvement with maternal health and behavioral health components. In 2023, fifty-seven acute care hospitals were participating in Year 3 of a proposed 5-year program—with forty-three participating in the maternal health component and fifty-four participating in the behavioral health component. For more information, please see https://qip-nj.nj.gov/.

Maternal Health
Aligning with the NurtureNJ campaign of First Lady Tammy Murphy, New Jersey continues its work towards improving the state's maternal and infant health outcomes—with a focus on reducing racial disparities. New Jersey's 2023 maternal health initiatives include:

- *Expanding postpartum coverage to 12 months after the end of the pregnancy:* With the end of the federal COVID-19 public health emergency and the start of unwinding in 2023, postpartum NJ FamilyCare members are currently receiving the expanded postpartum coverage (an increase from 60 days postpartum prior to the PHE).
- *Non-reimbursement for early elective deliveries*: Since 2021, NJ FamilyCare has not reimbursed providers, including facilities, for non-medically indicated early elective deliveries. NJ FamilyCare providers have subsequently raised that there are certain instances of spontaneous deliveries and medically-necessary deliveries prior to 39 weeks of gestational age that cannot be captured with currently available diagnosis codes. In 2023, we released updated coding guidance for our providers to better reflect the intent of our non-reimbursement policy.
- *Supporting maternity-related care:* In 2023, NJ FamilyCare continued to match fee-for-service reimbursement rates for physician specialists and midwives to 100% of current Medicare rates for certain maternity-related services—as we have been doing since 2022.
- *Piloting innovation in quality improvement:* In April 2022, NJ FamilyCare launched its perinatal episode of care pilot. The program is a three-year pilot to test a new alternative payment for prenatal, labor, and postpartum services statewide. Its goal is to improve the quality of maternity care by incentivizing obstetrical providers to broadly engage in all aspects of their patient's care. In 2023, we launched Performance Period 2 with an expanded list of participating hospital-affiliated and community practices, relative to Period 1. For more information, please see https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html.

Child Health
New Jersey's 2023 child health initiatives include:

- *CMMI's Integrated for Kids Model:* Starting in January 2022, the NJ Integrated Care for Kids (NJ InCK) Model has been available to pediatric NJ FamilyCare members residing in Ocean and Monmouth counties. Since 2020, DMAHS has supported the efforts of NJ's grantees (led by Hackensack Meridian Health), who have received funding through a cooperative agreement from the federal Center for Medicare and Medicaid Innovation (CMMI) to implement the InCK Model in NJ. The NJ InCK Model has two components. One is a comprehensive screening that is available to all NJ FamilyCare children. The second is voluntary, family-centered, community based care coordination available only to the subset of children identified to have significant health complexity through screening. Both of these components are supported by a state payment model designed by the grantees and paid for by NJ FamilyCare. In 2023, DMAHS requested and received CMS approval to increase the rates associated with this payment model (effective September 2023) to better support the Model as we begin the third implementation year in 2024. This initiative is expected to continue through December 2026. For more

information, please see https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.

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 was to incentivize Managed Care Organizations (MCOs) to (1) better document the type, scope, frequency, amount, and duration of HCBS in member services plans, and (2) produce timelier, accurate, and valid claims reporting that corroborate the details for HCBS in the service plan. New Jersey 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 External Quality Review Organization (EQRO) in 2019. This incorporated Managed Long-Term Services and Supports (MLTSS) Performance measures calculated during the course of the annual HCBS Care Management Audit, in addition to a modified calculation of the current Performance Measure #13 (PM #13). (PM #13 – MLTSS/HCBS services 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 Technical Assistance (TA) for the VBP for HCBS ended in July 2019. Phase 1 of the VBP was initiated in 2020 and concluded in late 2021. Phase 2 began in late 2021 and was completed in May of 2023.

VBP MLTSS Service Delivery

Phase 2 of the 2021 VBP MLTSS Service Delivery is based on the measurement period of January 1, 2020 to December 31, 2020, and evaluates the delivery of four service types to MLTSS members compared with authorized services, scope, quantity, and frequency as identified in the POC for HCBS members enrolled in the Medicaid Managed Care MLTSS program. The utilized services assessed in this methodology are: Home Delivered Meals (HDM), Medical Day Care (MDC), Personal Care Assistance (PCA), and Personal Emergency Response System (PERS). The percent of services delivered for each service type is calculated based on the average percent of services delivered by evaluating Plans of Care, Claims data, Blackout Periods, and Planned Service Discontinuations.

In addition to evaluating the delivery of services in accordance with the POC, MCOs are evaluated against the following Performance Measures (PMs): PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS, PM #10: Plans of Care aligned with member's needs based on the results of the NJ Choice Assessment, and PM #11: Plans of Care developed using "Person-Centered Principles". A sample was selected for each MCO, based on the authorization data and enrollment provided by the MCOs for the measurement period. MCOs are required to provide claims data files, source code, POCs, and supplemental documentation of Care Management (CM) notes for validation. In addition to the POCs submitted for the MLTSS Service Delivery samples, New Jersey Choice Assessment (NJCA) data was used to evaluate MCO compliance with PM #10. Compliance with PM #11 was determined based on a review of the POCs submitted for MLTSS Service Delivery.

The EQRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected from claims processed by the MCOs. The MCOs provided periods of events during when services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (Blackout Periods and Planned Service Discontinuations). Primary Source Verification (PSV) sessions are held with each MCO to ensure that reported claims accurately reflect the claims processed in their transactional systems. MCOs are given the opportunity to resubmit files for any issues identified during the PSV session, including claims data, source code, and Blackout Period files. DMAHS review of rate calculations and MCO attestation was completed in May 2023.

MLTSS Home and Community Based Services (HCBS) Performance Payment

The Division's HCBS Performance Payment is designed to award top performance in Plan of Care development within the MLTSS Program. Introduced in the January 2022 Contract, beginning with SFY 2023, the Division will award the top two (2) Contractors using data collected by the External Quality Review Organization (EQRO) pertaining to the MLTSS HCBS Care Management Audit Performance Measures scores. Prior to SFY 2023, the Division awarded the top three (3) Contractors using data collected by the External Quality Review Organization (EQRO) pertaining to the MLTSS HCBS Care Management Audit Performance Measures scores. The following Performance Measures have been selected with reserved right to modify the measures chosen to calculate performance, as necessary: Performance Measure 8: Plans of Care established within required timeframe following MLTSS enrollment, Performance Measure 9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC redetermination, Performance Measure 9a: Plan of Care for MLTSS Members amended based on change of Member condition, Performance Measure 10: Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJ Choice assessment, Performance Measure 11: Plans of Care for MLTSS Members are developed using Person-Centered Principles.

MLTSS Nursing Facility Transition Incentive Program

The MLTSS Nursing Facility Transition Incentive program is designed to accelerate safe transitions where the Contractor has actively participated in successfully transitioning an enrollee from the Nursing Facility to the Community setting. Upon meeting eligibility criteria and submission documentation outlined in the Contract under Article 8.5.8 C., for each transition the MCOs will receive $20,000 up to the total ten (10) million dollars allocated for this program. Transition incentive payments occur quarterly following the Division's review and approval. MCOs with serious deficiencies may not be considered for the incentive until the deficiency is resolved.

Expansion of NJ WorkAbility

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

New Jersey continues a phased implementation of the legislative mandate and is moving towards full implementation in 2024. Progress this year includes extensive stakeholder engagement as well as consultation with and technical assistance from CMS. Beginning April 1, 2023, NJ WorkAbility launched Phase 1, removing the age and asset limit requirements. Additional technical assistance is needed to permit an eligible applicant to remain enrolled for up to a year after a job loss. Phase 2 system change requirements needed to remove income limits remain on track to go live in early 2024.

New Jersey continues to implement this important program expansion in close consultation with stakeholders and our federal partners.

New Jersey DMAHS Quality Strategy

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

The *2022 New Jersey DMAHS Quality Strategy* focused on achieving measurable improvement and reducing health disparities through three high priority goals. Based on the CMS Quality Strategy Aims framework, the State organized its goals by these aims: 1) better care; 2) smarter spending; and 3) healthier people, healthier communities.

CMS Aim 1: Better Care

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

CMS Aim 2: Smarter Spending

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

CMS Aim 3: Healthier People, Healthier Communities

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

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

Table 3: NJ DMAHS Quality Strategy Goals

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

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

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

IPRO's Assessment of the New Jersey DMAHS Quality Strategy

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

Recommendations to New Jersey DMAHS

Per *Title 42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations on how NJ DMAHS can target the goals and the objectives outlined in the State's Quality Strategy to better support improvement in the **quality** of, **timeliness** of, and **access** to health care services furnished to NJ MMC enrollees. As such, in 2022 IPRO recommended the following to the NJ DMAHS:

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

III. Validation of Performance Improvement Projects

Objectives

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

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

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

For January–December 2023, this ATR includes IPRO's evaluation of the April 2023 PIP update and August 2023 PIP report submissions and one PIP proposal submission. 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 EQR protocols. The MCOs will continue to submit project updates in April and August progress reports each year.

In June 2023, IPRO conducted the annual PIP training for the MCOs. During the training, IPRO reviewed implementing effective interventions based on robust, data-driven barrier analysis. The training focused on PIP development, implementation, and current PIP issues.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the DMAHS contracted with IPRO to validate the PIPs that were underway in 2023 (**Table 4**). Unless indicated as non-clinical, PIPs were clinical. PIPs that were at the final report stage or proposal are noted.

Table 4: Core Medicaid and MLTSS PIP Topics

MCO	MCO PIP Title(s)[1]	State Topic
Aetna Better Health New Jersey (ABHNJ)	**PIP 1:** Improving Access and Availability to Primary Care for the Medicaid Population (Non-Clinical – Core Medicaid)	Access and Availability (Non-Clinical)
	PIP 2: Increasing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits and Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP Proposal (Core Medicaid) Decreasing Member Grievances Related to Balanced Billing	Member Grievances (Non-Clinical)
	PIP 3: Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the	Improving Coordination of Care and Ambulatory Follow-up for Mental Health

MCO	MCO PIP Title(s)[1]	State Topic
	MLTSS Home and Community Based (HCBS) Population (MLTSS)	Hospitalization in the MLTSS HCBS Population
Amerigroup New Jersey, Inc. (AGNJ)	**PIP 1:** Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members (Non-Clinical – Core Medicaid)	Access and Availability (Non-Clinical)
	PIP 2: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP Proposal (Core Medicaid) Decreasing Member Grievances Related to Balance Billing	Member Grievances (Non-Clinical)
	PIP 3: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Population (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
Horizon NJ Health (HNJH)	**PIP 1:** Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits – Core Medicaid Membership. (Non-Clinical – Core Medicaid)	Access and Availability (Non-Clinical)
	PIP 2: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population. (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP Proposal (Core Medicaid) Complaints and Grievances - Core Medicaid Membership	Member Grievances (Non-Clinical)
	PIP 3: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
UnitedHealthcare Community Plan (UHCCP)	**PIP 1:** Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members (Non-Clinical – Core Medicaid)	Access and Availability (Non-Clinical)
	PIP 2: Improving Frequency of Well Visits in the First 30 months of Life and Compliance with Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP Proposal (Core Medicaid) Reducing Member Grievances for Medicaid Members	Member Grievances (Non-Clinical)
	PIP 3: Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
Fidelis Care/ WellCare Health Plans of New Jersey, Inc. (FC/WCHP)	**PIP 1:** Medicaid Primary Care Physician Access and Availability (Non-Clinical – Core Medicaid)	Access and Availability (Non-Clinical)
	PIP 2: Improving Early and Periodic Screening, Diagnostic, and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations (Core Medicaid)	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
	PIP Proposal (Core Medicaid) Core Medicaid Complaints and Grievances	Member Grievances (Non-Clinical)
	PIP 3: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations (MLTSS)	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Review Element 6: Results Table:
- Data Collection

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

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

Following the review of the listed elements, the review findings are considered to determine whether the PIP outcomes should be accepted as valid and reliable. Each PIP is then scored based on the MCO's compliance with elements 1–8 (listed above). The element is determined to be "met," "partial met" or "not met." Compliance levels are assigned based on the number of points (or percentage score) achieved. **Table 5** displays the compliance levels and their applicable score ranges.

Table 5: PIP Validation Scoring and Compliance Levels

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

PIP: performance improvement project; CMS: Centers of Medicare and Medicaid Services; MLTSS: Managed Long-Term Services and Supports; MCO: managed care organization; N/A: not applicable.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO reviewed the August 2023 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies (**Tables 6–11**). Current MCO-specific PIP scoring reports along with IPRO findings can be found in **Appendix A: January 2023–December 2023 NJ MCO-Specific Review Findings**.

Table 6: PIP State Topic #1: Core Medicaid Primary Care Providers Access and Availability

New Jersey MCO PIP Scoring Report **PCP Access and Availability (Non-Clinical)** **MY = Measurement Year**	**IPRO 2023 Scoring** **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2[1]	**AGNJ MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**FC/ WCHP MY 3**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	PM	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**2.5**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2[1]	**AGNJ MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**FC/ WCHP MY 3**
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	N/A	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	PM	M	M
Element 5 Overall Review Determination	**PM**	**M**	**PM**	**M**	**M**
Element 5 Overall Score	**50**	**100**	**50**	**100**	**100**
Element 5 Weighted Score	**7.5**	**15.0**	**7.5**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Non-Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2[1]	**AGNJ MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**FC/ WCHP MY 3**
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	PM	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	PM	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**PM**	**M**	**PM**	**M**
Element 7 Overall Score	**100**	**50**	**100**	**50**	**100**
Element 7 Weighted Score	**20.0**	**10.0**	**20.0**	**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	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	M	M	M	PM
Element 8 Overall Review Determination	**N/A**	**M**	**M**	**M**	**PM**
Element 8 Overall Score	**N/A**	**100**	**100**	**100**	**50**
Element 8 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N**	**N**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**70.0**	**90.0**	**92.5**	**90.0**	**90.0**
Validation Rating Percent	**87.5%**	**90.0%**	**92.5%**	**90.0%**	**90.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**High**	**High**	**High**	**High**	**High**

[1]ABHNJ revised their aim statement and performance indicators in 2021 resulting in a new PIP cycle.

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

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

Table 7: PIP State Topic #2: Core Medicaid EPSDT Well Child Visits, Childhood Immunizations

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	PM
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	M	M	M
Element 5 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 5 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 5 Weighted Score	**7.5**	**15.0**	**15.0**	**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	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	PM	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	PM	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	PM
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**PM**	**PM**	**M**	**PM**
Element 7 Overall Score	**100**	**50**	**50**	**100**	**50**
Element 7 Weighted Score	**20.0**	**10.0**	**10.0**	**20.0**	**10.0**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**72.5**	**70.0**	**70.0**	**80.0**	**62.5**
Validation Rating Percent	**90.6%**	**87.5%**	**87.5%**	**100%**	**78.1%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**High**	**High**	**High**	**Moderate**

Element 8 is not scored during measurement years 1 and 2.
≥ 85% met; 60-84% partial met (corrective action plan); <60% not met (corrective action plan)

Table 8: PIP Proposal State Topic: Core Medicaid Member Grievances

New Jersey MCO PIP Scoring Report Member Grievances (Non-clinical) Proposal Year[1]	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**FC/WCHP**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	N/A	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 1 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Member Grievances (Non-clinical) Proposal Year[1]	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**FC/WCHP**
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 2 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	N/A	N/A	N/A	N/A
3b. Performance Indicators are measured consistently over time	N/A	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	N/A	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	N/A	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 3 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	N/A	N/A	N/A	N/A
4f. Literature review	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 4 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Member Grievances (Non-clinical) Proposal Year[1]	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**FC/WCHP**
5c. New or enhanced, starting after baseline year	N/A	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 5 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 6 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Score	N/A	N/A	N/A	N/A	N/A
Element 7 Weighted Score	N/A	N/A	N/A	N/A	N/A
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	N/A	N/A	N/A	N/A	N/A

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	N/A	N/A	N/A	N/A	N/A
Actual Weighted Total Score	N/A	N/A	N/A	N/A	N/A
Validation Rating Percent	N/A	N/A	N/A	N/A	N/A
Validation Status	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report Member Grievances (Non-clinical) Proposal Year[1]	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**AGNJ**	**HNJH**	**UHCCP**	**FC/WCHP**
Validation Rating	N/A	N/A	N/A	N/A	N/A

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

Table 9: PIP State Topic #3: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	PM
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**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	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	PM
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	PM	M	M	M	M
Element 5 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 5 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 5 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	PM	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**PM**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**50**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**2.5**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results).					

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2023 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 2	**AGNJ MY 2**	**HNJH MY 2**	**UHCCP MY 2**	**FC/WCHP MY 2**
Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	PM	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**10.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**72.5**	**70.0**	**80**	**77.5**	**65**
Validation Rating Percent	**90.6%**	**87.5%**	**100%**	**96.9%**	**81.3%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**High**	**High**	**High**	**Moderate**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan)

Table 10 presents comparative performance for all MCOs across all PIP topics reviewed August 2023.

Table 10: 2023 PIP Validation Results

MCO Compliance Level	PIP 1[1]	PIP 2[1]	PIP Proposal[1,2]	PIP 3[3]
	Access and Availability	EPSDT – Well-Child Visits & Childhood Immunizations	Member Grievances	Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population
ABHNJ	87.5%	90.6%	N/A	90.6%
AGNJ	90.0%	87.5%	N/A	87.5%
HNJH	92.5%	87.5%	N/A	100.0%
UHCCP	90.0%	100.0%	N/A	96.9%
FC/WCHP	90.0%	78.1%	N/A	81.3%

[1] Performance improvement projects (PIPs) 1 and 2 are Core Medicaid PIPs.
[2] Managed care organizations (MCOs) are at the proposal stage for this PIP and will be scored in measurement year (MY) 1.
[3] PIP 3 is a Managed Long-Term Services and Supports (MLTSS) PIP.
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; HCBS: Home and Community Based Services.

Strengths

ABHNJ – Of the 3 PIPs scored, 2 performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

AGNJ – Of the 3 PIPs scored, 2 PIPs performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

HNJH – Of the 3 PIPs scored, 2 performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

UHCCP – Of the 3 PIPs scored, 2 performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

FC/WCHP– Of the 3 PIPs scored, 1 performed above the 85% threshold for Core Medicaid, indicating high performance.

Opportunities for Improvement

ABHNJ – Overall, ABHNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of performance indicator results and additional interventions that specifically address barriers identified. In addition, all calculations should be reviewed and verified prior to submitting PIP reports.

AGNJ – Overall, AGNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring statistical techniques described in the data analysis plan are actually conducted in the analysis and ensuring consistency in aim statement and goal rates (percentage change versus percentage point change).

HNJN – Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of performance indicator results and disparities presented. In addition, all calculations should be reviewed and verified prior to submitting PIP reports.

UHCCP – Overall, UHCCP was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring all available data are included for analysis of performance indicator results.

FC/WCHP– Overall, FC/WCHP was partially compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring barrier analyses are comprehensive and drive appropriate interventions and sufficiently addressing factors that impact external validity of performance indicator results.

All five MCOs engaged in a Core Medicaid PIP relating to Access and Availability. **Table 11** lists the interventions that each MCO implemented for this project, and were provided verbatim by the MCOs.

Table 11: PIP Interventions Summary 2022–2023 for Access and Availability

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

PIP	Interventions
AGNJ - Increasing Primary Care Physician (PCP) Access and Availability for the Amerigroup Members	• **Education** via fax to all in-network provider groups regarding improving access and availability (including telehealth options). (Quarterly) • **Monitoring the number of telehealth visits** of the identified provider groups who received faxed telehealth education.
	• **Quarterly meeting** with identified provider groups for education and discussion of barriers, appointment availability and PCP visit data. • **Monitoring the number of PCP visits** (any type) of the identified provider groups who received education and barrier discussions.
	• **Text messaging** (3 times per year) to members attributed to the identified provider groups who have not had a PCP visit to stress the importance of preventative health visits to avoid inpatient admissions. • **Telephonic outreach** to members of the identified provider groups with failed text. • **Educational mailing** targeting members of the identified provider groups with failed texts and/or call restrictions (do not call carve outs) regarding the importance of PCP visits.
	• **Faxed list of attributed** members who have not had a PCP visit (well and sick) in the last year for the identified provider groups.
	• **Promotion and tracking** of provider incentive for well visits.
	• **Promotion and tracking** of member incentives for preventative services.
HNJH - Increasing PCP Access and Availability for members with low acuity, Non-emergent ED visits-Core Medicaid Membership	• **Educational materials** mailed to any member annually that experiences a LANE ED visit and has not had a PCP visit within the last 12 months. Education would be personalized to include the assigned PCP contact information, telemedicine alternatives, importance of annual visits, including preventive health screenings and immunizations, information on transportation and if additional assistance is needed. Education would also include when and when not to utilize the ED. **Visit reminders** sent to members biannually. Reminders are personalized to include the PCP contact information, contact information for transportation and if additional assistance is needed.
	• **Quarterly touchpoint meetings** with providers and staff in participating practice groups to focus on progress, newly encountered issues, or barriers of having members complete annual and follow-up visits. • **Bi-monthly list** sent to providers in participating practice groups of members with a LANE ED visit that have not been seen by the provider within 12 months.
UHCCP – Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members	• **Contact** Newark Community Health Centers, Rhomur Medical Services, and Forest Hills Family Health Associates adult Medicaid members who had an avoidable ED visit. Interview them about barriers to receiving care from a PCP on the day of the ED visit, educate them about appropriate ED usage, alternative sites of care and annual wellness visit.
	• **Assist in scheduling an appointment** with PCP for the adult Medicaid members assigned to Newark Community Health Centers, Rhomur Medical Centers and Forest Hills Family Health Associates who had an avoidable ED visit in the past quarter and are overdue for their annual physical.
	• **If the Newark Community Health Center, Rhomur Medical Services and Forest Hills Family Health Associates** adult Medicaid member indicates lack of transportation as a barrier to visiting the PCP office, educate them on medical transportation benefits offered by Medicaid.
	• **Work collaboratively** with identified practices to increase and monitor urgent appointment availability in order to reduce avoidable ED utilization.
	• **Refer adult Medicaid members** assigned to Newark Community Health Centers, Rhomur Medical Services and Forest Hills Family Health Associates who are high ED utilizers (4+ visits per calendar year) to NJUHCCP Case Management department for evaluation for services.

PIP	Interventions
FC/WCHP–Medical Primary Care Physician Access and Availability	• **Telephonic outreach** to members (quarterly) who had two or more visits to the emergency room or the urgent care center in the past six (6) months. • **The proportion of providers** who were telephonically outreached and educated about Medicaid Appointment Availability Standards. • **The proportion of providers** whose members indicated that they could not receive timely appointments and were educated about Medicaid Appointment Availability standards. • **The proportion of IPAs** that were outreached and educated on the Access and Availability standards. • **The proportion of the providers** who were given the handouts for display in their office.
	• **Implementation of provider outreach** to update their demographic profile via email or phone call.
	• **The proportion of providers** who required ER/urgent care discussion based on their member utilization patterns.

PIP: performance improvement project; PCP: primary care provider; ER: emergency room; LANE: low-acuity, non-emergent; MY: measurement year; IVR: interactive voice response; ED: emergency department.

All five MCOs engaged in a Core Medicaid PIP relating to EPSDT. **Table 12** lists the interventions that each MCO implemented for this project, and were provided verbatim by the MCOs.

Table 12: PIP Interventions Summary 2022–2023 for EPSDT: Increasing Early and Periodic Screening, Diagnostic, and Treatment Visits and Childhood Immunizations

PIP	Interventions
ABHNJ - Increasing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits and Childhood Immunizations	• **Educate non-adherent members** with well-child visits and/or immunizations about importance of visits and safety of vaccines IVR through HealthCrowd. The Plan will be specifically tracking the African American children for non-adherence due to vaccine hesitancy and lack of trust in the medical community.
	• **Identify members** without PCP claims in the system on a quarterly basis (12-month look-back) and conduct member outreach for engagement and/or PCP reassignment.
	• **Provide roster to select providers** in targeted counties identifying new members on the panel with no well-child visits and/or no CIS combo 10 (formerly combo 9) vaccinations. Appointments to be monitored through quarterly claims data.
	• **Send letter to members** with a brochure who do not have claims for well-child visits and/or CIS combo 10 (formerly combo 9) vaccinations on behalf of PCP for select provider offices that ABHNJ manages and mailings which include incentive information. The member letter will include the provider and Plan logo with the provider signature.
AGNJ - Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months	• **Parent/guardian education** on the importance of well visits and immunizations.
	• **Telephonic outreach** to parents/guardians of children ages 0-30 months identified as missing well visits.
	• **Parents/guardians** with children ages 0-30 months identified as missing well visits that required transportation assistance during telephonic outreach.
	• **Web-based member** education regarding vaccine safety.
	• **Outreach to providers** identified as having 10% or more of eligible members with gaps in care for well visits and immunizations.
	• **Targeted education for pediatricians** and family practice physicians on correct coding of well visits via fax blast.
	• **Implementation and promotion** of provider incentive for vaccine administration.
	• **Outreach to Passaic County provider groups** with gaps in care for well visits and immunizations to provide best practices and education (15 or more gaps in care for identified membership with disparity in Passaic County).

PIP	Interventions
	• **Targeted education via text or telephonic outreach** to identified parents/guardians of children ages 0-30 months identified as missing well visits and immunizations (Passaic County membership with disparity - Hispanic).
HNJH - Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population.	• **Parent/guardians** of new HNJH members less than 30 months of age will be sent targeted mailer highlighting recommended immunization schedule and the ability to obtain combination doses. Phone number for scheduling assistance will also be included. • **Monthly member gap lists** to primary care providers caring for children less than 30 months of age with list of members due for upcoming WCV and CIS to better assist in appointment scheduling prior to recommended WCVs and CIS.
	• **Parent/guardians** of HNJH members sent a reminder postcard that the member is behind schedule to complete six (6) well-child visits with their PCP by 15 months of age. Children 12 months of age or older with no well-child visits on record will be targeted for the reminder. • **Parent/guardians of HNJH** members sent a reminder postcard that the member is behind schedule to complete two (2) well-child visits with their PCP by 30 months of age. Children 22 months of age or older with no well-child visits on record will be targeted for the reminder.
	• **Semi-annually deliver flier** to PCPs explaining ModivCare availability and how members may utilize their services to access the PCP. Information can be disseminated when attempting to schedule members with transportation challenges.
UHCCP - Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations.	• **Outreach to the parents/caregivers** of members assigned to Practice 1, 2 and 3 to remind them to schedule/keep their scheduled well baby appointments, educate on importance of preventive care.
	• **Provide case management** referral to parents/caregivers of members assigned to Practice 1, 2 and 3 who express that social determinants of health (relating to food, housing, or transportation) present a barrier to bringing their child for the well-baby visits.
	• **Monthly practice outreach/education** by UHCCP Clinical Practice Consultants (CPCs) to the staff at Practice 1, 2 and 3 regarding scheduling the well-baby appointment before the parent/caregiver leaves the office after a well-baby visit and reinforcing the importance of providing education to the member parent/caregiver regarding adherence to the recommended immunization and well-baby visit schedule.
FC/WCHP- Improving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Well Child Visits and Childhood Immunizations	• **Provide the following educational website** for parent/guardian education: Share and discuss the *NEW Bright Futures Family Tip Sheet* consistent with *Bright Futures Guidelines*, *The Well-Child Visit: Why Go and What to Expect*. Provide the following educational materials via mailings for parent/guardian education: Childhood Vaccine Schedule Krames; Well Child Check-up Krames; Preventative Guidelines Ages 2-18 Krames. • **Implementation of monthly** parent/guardian outreach to educate new mothers on the importance of well-child visits and immunizations. • **Quarterly Engagement** of 2 pilot providers to include: provider education of the PIP; delivery of provider score card to include WCV/immunization care gaps; familiarize providers with the *Bright Futures Performing Preventive Services Handbook*, which provides guidance on the most effective way to deliver the preventive services recommended in the *Bright Futures Guidelines, 4th Edition*. • **Mail expectant mothers** the *2021 Bright Futures Vaccine Schedule* and *Well Child Visits*. • **Identify parents/guardians with open care gaps due to language barrier.**

PIP: performance improvement project; PCP: primary care provider; IVR: interactive voice response; CIS: childhood immunization status; WCV: well-child visit.

All five MCOs engaged in an MLTSS PIP relating to Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS HCBS Population. **Table 13** lists the interventions that each MCO implemented for this project, and were provided verbatim by the MCOs.

Table 13: PIP Interventions Summary 2022–2023 for Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS HCBS Populations

PIP	Interventions
ABHNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Increase documented interactions** between BH UM and MLTSS CM at least 3 times before member is discharged to ensure outpatient follow-up needs are met. Documented interactions can be defined as: communication via telephone, email, or in-person after admission, following concurrent review and at the time of discharge, participation in a BH UM rounds. • **BH UM will send** the discharge clinical information to the MLTSS CM within 48 hours following receipt from the hospital.
	• **Formalized information** gathering for social determinants of health for all members will occur during the BH UM discussions to facilitate discharge planning. • **MLTSS HCBS members** with a behavioral health inpatient admission that have an identified SDoH issue or have been identified as being at high risk for nonadherence to discharge plan (based on the *Immediate Outreach Trigger List*) will receive outreach post discharge by their MLTSS CM within 48 business hours of the BH UM receiving discharge information from the facility to troubleshoot and resolve any barriers to attending behavioral health follow-up.
	• **BH UM will coordinate** the scheduling of a MH follow-up visit pre-discharge. If appointment is scheduled > 7 days from discharge, BH UM will educate providers regarding BH appointment standards. If the scheduled appointment is not shared before discharge or the appointment is outside of the 7- and 30-day timeframe, the MLTSS care manager will work with the member to get an appointment scheduled within the appropriate timeframe. • **MLTSS care manager** will coordinate the scheduling of a BH follow-up visit post-discharge if an appointment is not scheduled.
AGNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Increase network of telehealth** mental health practitioners to improve appointment availability.
	• **Behavioral health team** to contact mental health provider to schedule/reschedule follow-up appointment for MLTSS HCBS members (within 7- and 30-days post discharge).
	• **Face-to-face or telephonic visits** by a Behavioral Health Case Manager for hard-to-reach MLTSS HCBS members discharged from the hospital
	• **Implementation and promotion** of provider incentive for FUH Compliance (7 Day-follow up and 30- Day follow-up).
	• **Monthly fax blast to outlier facilities due to late discharge notification**. Education material details importance of prompt discharge planning and notification**.**
HNJH - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **The MLTSS care manager** will review generalized educational material with the member (regarding the stigma of mental illness, the importance of treatment and where to find help) emphasizing the importance of routine wellness visits to members with a HEDIS-defined MH diagnosis.
	• **The CM will outreach** to engage and collaborate with any identified personal representatives, assisted living staff or house managers (boarding homes/group homes) as possible, regarding the importance of post-facility ambulatory care within 10 business days of hospital discharge. • **The CM will outreach** the member and provide generalized education emphasizing the importance of routine wellness visits to members with a HEDIS-defined MH diagnosis. • **The CM will escalate and refer** any member with a mental health related hospital readmission during the review period for the bi-weekly "Readmission Rounds Meeting" to be further reviewed by the MLTSS and BH Interdisciplinary Team meeting.

PIP	Interventions
	• **The MLTSS care manager** will conduct outreach within 3 business days of an identified inpatient mental health related hospital discharge, this will allow the care managers to address the members needs with mental health related conditions sooner than the contractual timeframes. In addition, the MLTSS care manager will conduct a 30-day pledge post hospital, which includes a Face-to-Face visit within 10 calendar days and weekly telephonic outreach. • **The Outpatient mental health care providers** for MLTSS members with HEDIS-defined mental health related dx and acute mental health related hospital discharge, will be outreached post hospital discharge. Outreach to include; offer for assistance with care coordination and confirmation of post-facility follow-up appointment, share MLTSS CM contact information and request for outreach with member concerns or non-adherence with appointments. • **The MLTSS team will review** "claim discrepancy" twice monthly to help identify any previously unidentified hospitalizations covered by another payor, i.e., Medicare or other commercial plans and outreach member for post-facility outreach. • **Inpatient mental health providers** will be educated on the importance of timely notification of inpatient admissions regardless of payor and reeducated on use of the Horizon Alert forms to help support and improve collaboration and the success of discharge planning.
	• **The MLTSS Care Management** and Behavioral Health teams will assist with coordinating follow-up care appointment for members following mental health related hospital discharge. • **MLTSS members with HEDIS**-defined mental health related diagnosis and an acute mental health related hospital discharge, will be provided with education on use and availability of telehealth appointments during the post-facility contact.
UHCCP - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Behavioral health advocate care manager** will make at least 3 attempts to contact the discharged member to establish care management services.
	• **Behavioral health advocate care manager** and MLTSS care manager collaborate with the hospital discharge planner to make sure that member's follow-up appointment is scheduled prior to member's discharge, for the date within 30 days of discharge. • **Behavioral health advocate care manager** follows up that an appointment with a behavioral health provider is scheduled for the date within 30 days of discharge and member is aware of the scheduled appointment. • **Member's behavioral health advocate care manager**, MLTSS care manager and behavioral health medical director hold an interdisciplinary team meeting to discuss the recently admitted member's plan of care within 1 week of member's inpatient admission notification.
	• **Behavioral health advocate care manager** provides a reminder phone call to the member 24–48 hours prior to the follow-up appointment. • **Behavioral health advocate care manager** follows up with member after the scheduled appointment to determine if the follow-up appointment was completed. • **Behavioral health advocate care manager** follows up with member's provider after the scheduled appointment to determine if the follow-up appointment was completed. • **If member did not complete** their appointment, behavioral health advocate care manager reschedules the missed appointment.
	• **If the behavioral health advocate health care manager** determines that lack of transportation prevents the member from completing the follow-up appointment, they advise/assist the member in utilizing telehealth to complete a follow-up visit with a mental health practitioner. • **If the behavioral health advocate health care manager** determines that lack of transportation prevents the member from completing the follow-up appointment, they

PIP	Interventions
	assist the member in arranging medical transportation to complete a follow-up visit with a mental health practitioner.
	• **Behavioral health advocate care manager and MLTSS care manager** follow up that member who declines to complete a follow-up visit with a mental health provider within 30 days of discharge completes a follow-up visit with a primary care provider within 30 days of discharge.
FC/WCHP-Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **WellCare to coordinate provider** training on a quarterly basis on the identification of factors impacting member follow-up and adherence to treatment protocols among members with a behavioral health diagnosis.
	• **Screening for SDoH factors** that present barriers for follow-up treatment for members who have been recently discharged from an acute care setting with behavioral health diagnosis. • **Track referrals made** to community based MLTSS services for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Track referrals made** to community based resources for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services.
	• **Outreach members** identified with a recent behavioral health acute inpatient discharge and complete the Initial Contact for Behavioral Health Discharges Screening tool.
	• **Document member preference** of either in-person or telehealth follow-up visits with primary care/specialist. Track utilization of telehealth services for 30-day follow-up visit among the members meeting criteria for the project.

PIP: performance improvement project; MLTSS: Managed Long-Term Services and Supports; BH: behavioral health; CM: care management/care manager; UM: utilization management; SDoH: social determinants of health; MH: mental health; FUH: follow-up after hospitalization; HEDIS: Healthcare Effectiveness Data and Information Set.

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

Objectives

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. To meet these federal requirements, DMAHS has contracted with IPRO, an EQRO, to conduct the Review of Compliance with Medicaid and CHIP Managed Care Regulations. The Annual Assessment of MCO Operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of *Title 42 CFR § 438.360(a)(1)*. The Annual Assessment of MCO Operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. All five MCOs participated in a 2023 compliance review: ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP. *Note: WellCare Health Plans of NJ, Inc. began doing business as Fidelis Care in August 2023.*

In 2023, all audits were conducted virtually (offsite). Staff interview questions were not provided prior to the offsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the offsite interview. The Plan was provided with an opportunity to clarify responses and to provide requested documentation after the virtual interviews.

Effective 2019, the state moved to a new annual assessment audit cycle: 2 consecutive years of partial audits followed by 1 year of full audit. If the MCO scores less than 85% in the first partial audit, the MCO will have a full audit the following year. In 2023, partial reviews were conducted for ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP. The reviews evaluated each health plan on 14 standards based on contractual requirements. The MCOs were required to provide documentation on one additional standard (Member Disenrollment). IPRO developed a submission guide for this category, and the MCOs were required to provide evidence of compliance for 29 Member Disenrollment elements for Core Medicaid and MLTSS. IPRO reviewed and scored the elements based on the documentation provided. Scores for this standard are included within the 2023 Annual Assessment final reports for each MCO.

The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP in 2023 is outlined in **Table 14.**

Table 14: 2023 Annual Assessment Type by MCO

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

MCO: managed care organization.

Technical Methods of Data Collection and Analysis

IPRO reviewed each MCO in accordance with the 2023 CMS Protocol, "EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."

The review consisted of pre-offsite review of documentation provided by the plan as evidence of compliance with the 14 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and audit activities. To assist in submission of appropriate documentation,

IPRO developed the *Annual Assessment of MCO Operations Review Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by review standard (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. The submission guide was provided to the plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was July 1, 2022, to June 30, 2023.

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

Recommendations and Opportunities for Improvement

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

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

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

Description of Data Obtained

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

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

- ***Policies and Procedures*:** Policies are pre-decisions made by appropriate leadership for the purpose of giving information and direction. Policies establish the basic philosophy, climate, and values upon which the MCO bases all its decisions and operations. Procedures are the prescribed means of accomplishing the policies. Effectively drawn procedures provide an MCO with the guidelines and, where appropriate, the specific action sequences to ensure uniformity, compliance, and control of all policy-related activities.

Examples of policies and procedures reviewed by IPRO include grievances, enrollee rights, and credentialing.

- ***Communications****:* These include all mechanisms used to disseminate general information or policy and procedure updates for enrollees, staff, providers, and the community. IPRO reviewed examples of communications that included the MCO's member newsletters, the provider manual, website, notice of action (NOA) letters, and the employee handbook.
- ***Implementation:*** IPRO evaluated documents for evidence that the MCO's policies and procedures have been implemented. IPRO reviewed documents including committee meeting minutes, organizational charts, job descriptions, program descriptions, flow charts, tracking reports, and file reviews as applicable.

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

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

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

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

Conclusions and Comparative Findings

As part of the Annual Assessment of MCO Operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI Standards. CMS requires each MCO's compliance with these fourteen (14) standards be evaluated. **Table 16** provides a crosswalk of individual elements reviewed during the Annual Assessment to the CMS QAPI Standards.

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

Subpart D and QAPI Standards[1]	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[2]
Disenrollment	438.56	1 – Member Disenrollment	MD1-MD8, MD10	1 – 2023–2024
Enrollee Rights	438.100	1 – Enrollee Rights and Responsibilities	ER1, ER3 - ER4	1 – 2022–2023 and 2023–2024
Emergency and Post Stabilization	438.114	1- Access	A1	1 – 2022–2023 and 2023–2024

Subpart D and QAPI Standards[1]	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[2]
Availability of services	438.206	1 – Access, 2 – Credentialing and Recredentialing 3 – Administration and Operations	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024 3 – 2022–2023 and 2023–2024
Assurances of adequate capacity and services	438.207	1 – Access	A4	1 – 2022–2023 and 2023–2024
Coordination and continuity of care	438.208	1 – Care Management and Continuity of Care	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	1 – 2022–2023 and 2023–2024
Coverage and authorization of service	438.210	1 – Utilization Management	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	1 – 2022–2023 and 2023–2024
Provider selection	438.214	1 – Credentialing and Recredentialing 2 – Care Management and Continuity of Care	CR2, CR3, CM27	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024
Confidentiality	438.224	1 – Provider Training and Performance	PT9	1 – 2022–2023 and 2023–2024
Grievance and appeal systems	438.228	1 – Utilization Management 2- Quality Management	UM16a – UM16d, UM16f- UM16i, QM5	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024
Subcontractual relationships and delegation	438.230	1 – Administration and Operations	AO5, AO8–AO11	1 – 2022–2023 and 2023–2024
Practice guidelines	438.236	1 – Quality Assessment and Performance Improvement (QAPI) 2 – Quality Management 3 – Programs for the Elderly and Disabled	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024 3 – 2022–2023 and 2023–2024
Health information systems	438.242	1 – Management Information Systems	IS1–IS17	1 – 2022–2023 and 2023–2024
Quality assessment and performance improvement (QAPI)	438.330	1 – Quality Assessment and Performance Improvement (QAPI)	Q1-Q3, Q5-Q9	1 – 2022–2023 and 2023–2024

[1] The categories QAPI and Care Management and Continuity of Care are reviewed annually. DMAHS requires specific elements to be reviewed annually.

[2] Within a 3-year cycle, four MCOs (ABHNJ, AGNJ, HNJH and UHCCP) had a partial compliance review in 2021–2022. One MCO (WCHP) had a full compliance review in 2021–2022. Four MCOs (ABHNJ, AGNJ, HNJH and UHCCP) had a full compliance review in 2022–2023. One MCO (FC/WCHP) had a partial compliance review in 2022–2023. All five MCOs had a partial compliance review in 2023–2024.

Of the 228 elements reviewed during the 2023 Core Medicaid and MLTSS Annual Assessments, 94 elements crosswalk to the fourteen (14) CMS QAPI Standards. **Table 17** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI Standards identified by CMS.

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

Subpart D and QAPI Standards	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	AGNJ	HNJH	UHCCP	FC/ WCHP
Disenrollment	438.56	MD1-MD8, MD10	9	67%	78%	89%	100%	100%
Enrollee rights	438.100	ER1, ER3 -ER4	3	100%	100%	100%	100%	100%
Emergency and post stabilization	438.114	A1	1	100%	100%	100%	100%	100%
Availability of services	438.206	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	67%	58%	75%	67%	58%
Assurances of adequate capacity and services	438.207	A4	1	100%	0%	100%	100%	0%
Coordination and continuity of care	438.208	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	11	55%	55%	64%	64%	73%
Coverage and authorization of services	438.210	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	7	100%	100%	100%	100%	100%
Provider selection	438.214	CR2, CR3, CM27	3	100%	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16a – UM16d, UM16f-UM16i, QM5	9	89%	100%	89%	100%	56%
Subcontractual relationships and delegation	438.230	AO5, AO8– AO11	5	100%	100%	100%	100%	100%
Practice guidelines	438.236	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%	100%
Health information systems	438.242	IS1–IS17	17	100%	94%	100%	100%	100%
Quality assessment and performance improvement program	438.330	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%	100%
Total elements reviewed			94					
Compliance percentage				86%	85%	90%	91%	86%

All five (5) MCOs participated in the 2023 Compliance Review. A total of 228 elements were reviewed by each MCO for a total of 1,140 elements reviewed overall (data not shown). All five (5) NJ MCOs showed strong performance in the CMS Subpart D and QAPI Standards. All five MCOs received 100% compliance for 8 of the 14 standard domains. All five (5) MCOs were non-compliant in Availability of Services, and in Coordination and Continuity of Care (**Table 17**).

Table 18 displays a comparison of the overall compliance score for each of the five MCOs from 2022 to 2023. For the review period July 1, 2022–June 30, 2023, ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP scored above NJ's minimum threshold of 85%. The 2023 compliance scores from the annual assessment ranged from 93% to 97% (**Table 18**). ABHNJ's compliance score decreased from 97% to 96%; AGNJ's compliance score remained at 95%; HNJH's compliance score decreased from 98% to 97%, UHCCP's compliance score increased from 96% to 97%; FC/WCHP's compliance score decreased from 97% to 93%. (**Table 18**).

Table 18: Comparison of 2022 and 2023 Compliance Scores by MCO

MCO	2022 Compliance %	2023 Compliance %	% Point Change from 2022 to 2023
ABHNJ	97%	96%	-1%
AGNJ	95%	95%	0%
HNJH	98%	97%	-1%
UHCCP	96%	97%	+1%
FC/WCHP	97%	93%	-4%

MCO: managed care organization.

In 2023, the average compliance score for seven standards (Quality Management, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, Credentialing and Re-Credentialing, and Administration and Operations) showed increases ranging from 1 to 4 percentage points (**Table 19**). In 2023, seven standards (Quality Assessment and Performance Improvement, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, and Administration and Operations) had an average score of 100%. Average compliance for two standards (Quality Assessment and Performance Improvement and Efforts to Reduce Healthcare Disparities) remained the same from 2022 to 2023 (**Table 19**). Four standards (Access, Satisfaction, Utilization Management and Management Information Systems) decreased 1 to 10 percentage points from 2022 to 2023. Access had the lowest average compliance score at 69% (**Table 19**).

Table 19: 2022 and 2023 Compliance Scores by Review Category

Review Category[1]	MCO Average 2022[2]	MCO Average 2023[2]	Percentage Point Change
Care Management and Continuity of Care – Core Medicaid[1]	79%	75%	-4%
Care Management and Continuity of Care – MLTSS[1]	100%	100%	0%
Access	79%	69%	-10%
Quality Assessment and Performance Improvement	100%	100%	0%
Quality Management	92%	93%	+1%
Efforts to Reduce Healthcare Disparities	100%	100%	0%
Committee Structure	96%	100%	+4%
Programs for the Elderly and Disabled	99%	100%	+1%

Review Category[1]	MCO Average 2022[2]	MCO Average 2023[2]	Percentage Point Change
Provider Training and Performance	98%	100%	+2%
Satisfaction	100%	96%	-4%
Enrollee Rights and Responsibilities	97%	100%	+3%
Member Disenrollment[4]	N/A	94%	N/A
Credentialing and Recredentialing	94%	96%	+2%
Utilization Management	100%	96%	-4%
Administration and Operations	99%	100%	+1%
Management Information Systems	100%	99%	-1%
Total[3]	97%	96%	-1%

[1] In 2022 and 2023, the Care Management scores were not included in the overall compliance score.
[2] MCO average is the average of the compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP).
[3] Total is the average of compliance scores listed in **Table 19**.
[4] Member Disenrollment is a new standard reviewed in 2023.

Individual MCO 2023 Annual Assessment scores by element can be found in **Appendix A: January 2023–December 2023 NJ MCO-Specific Review Findings**.

Figure 2 depicts compliance scores since 2021. Compliance scores for the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP) have remained at or above 91% for all 3 years.

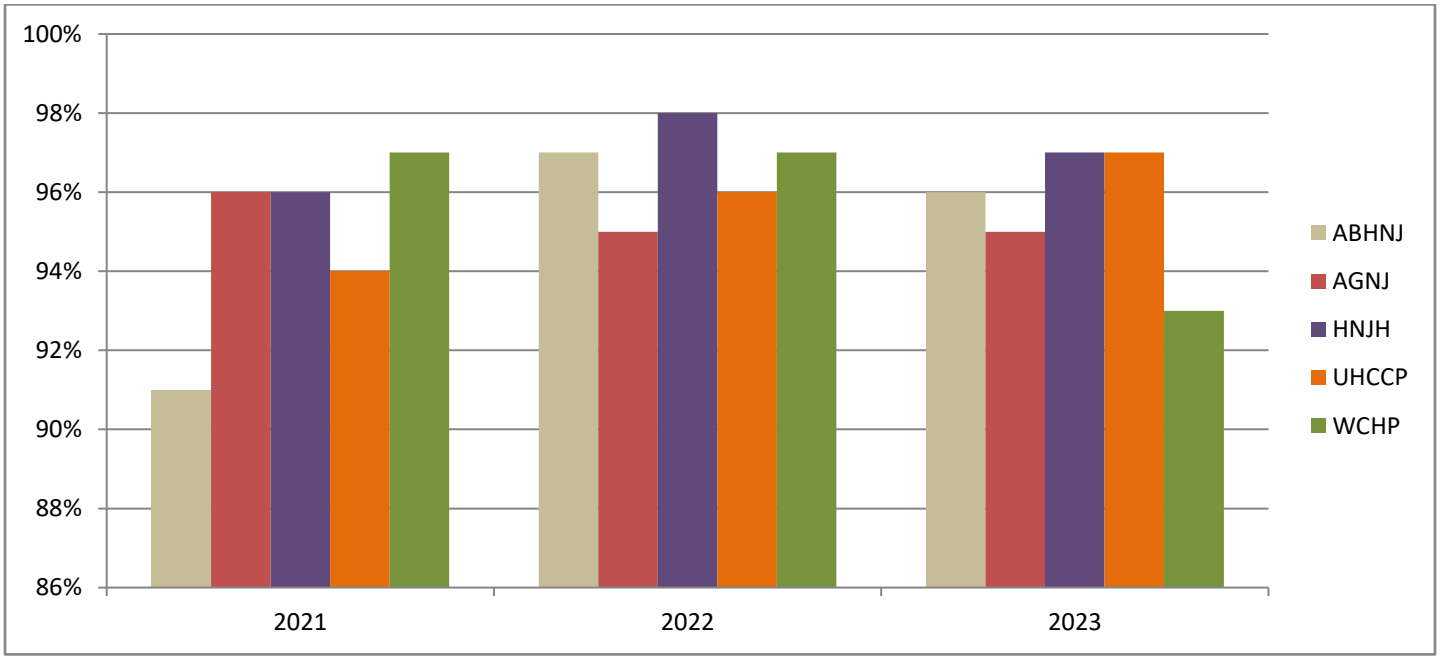

Figure 2: MCO Compliance Scores by Year (2021–2023). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, gray); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, purple), UnitedHealthcare Community Plan (UHCCP, orange); and WellCare Health Plans of New Jersey, Inc. d.b.a. Fidelis Care (FC/WCHP, green) are shown for 2021–2023.

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 2023 annual assessment of MCO operations are:

- The implementation and evaluation of a comprehensive QAPI program meets all of the compliance standards.
- The QAPI program delineates an identifiable committee structure responsible for performing QI activities and demonstrates ongoing initiatives.
- All five MCOs continue to perform well with regard to QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, and Administration and Operations.

V. Validation of Performance Measures

Objectives

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

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

Technical Methods of Data Collection and Analysis

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS FAR prepared by 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 **(Table 20).** In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used, and medical record review procedures relevant to the calculation of the hybrid measures.

Description of Data Obtained

The five MCOs with performance data for MY 2022 (ABHNJ, AGNJ, HNJH, UHCCP and FC/WCHP) reported HEDIS MY 2022 data. The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications, and there were no data collection or reporting issues identified by the MCOs' independent auditors.

IPRO reviewed each of the NJ MCOs' HEDIS MY 2022 FARs to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 20).**

Table 20: MCO Compliance with Information System Standards – MY 2022

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

MCO: managed care organization; IS: information system; HEDIS: Healthcare Effectiveness Data and Information Set.

Information Systems Capabilities Assessments

In 2020, IPRO worked with DMAHS to customize the ISCA worksheet of the protocols. Four of the five Medicaid MCOs in NJ offered both a Medicaid and a fully integrated dual eligible special needs plan (FIDE SNP) product. The fifth plan began offering the FIDE SNP product in January 2021. In addition to customizing the worksheet for the Medicaid products, it was also modified to include questions relating to the FIDE SNP product. The worksheet was provided to all MCOs on 7/15/2020. All MCOs returned the completed worksheet and requested documentation on 8/12/2020. IPRO conducted a meeting with DMAHS and the MCOs on 8/31/2020 to review the agenda and process. Due to COVID-19 restrictions, the reviews occurred via Cisco WebEx®.

The assessment covered the following areas:

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

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

All five MCOs undergo a systems review annually as part of their HEDIS audit by an NCQA-licensed organization. IPRO reviews these results annually. In addition to the annual review of information systems (IS) that is conducted during the annual HEDIS review for each MCO in NJ, the Annual Assessment review conducted by IPRO for each organization includes review of 18 separate elements. Review of the IS elements includes live demonstration of systems. In May 2024, a full ISCA will be conducted across all five NJ MCOs. Final report findings will be presented in the next ATR in 2025.

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

Table 21: Information Systems Capabilities Assessment Results for 2020

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

MCO:	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP
Standard[1]	Implications of Findings				
Ability of the information system to conduct MCO quality assessment and improvements initiatives.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Ability of the information system to generate complete, accurate, and timely T-MSIS data.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the information system for review of provider network adequacy.	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications
Utility of the MCO's information system for linking to other information sources for quality related reporting (e.g., immunization registries, health information exchanges, state vital statistics, public health data).	High-No implications	High-No implications	High-No implications	High-No implications	High-No implications

[1] Managed care organization (MCO) encompasses MCOs, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities described in *Title 42 CFR § 438.310(c)(2)*.
T-MSIS: Transformed Medicaid Statistical Information System.

HEDIS MY 2022 Performance Measures

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

Conclusions and Comparative Findings

All of the five MCOs included their non-FIDE Dual Eligible members in the HEDIS submission, where the MCO was also the MCO for the Medicare product, which followed the NCQA HEDIS MY 2022 guidance.

ABHNJ, HNJH, UHCCP, and FC/WCHP included FIDE SNP in their Medicaid reporting. Of the five MCOs with FIDE SNP products, AGNJ did not include their FIDE SNP members in the HEDIS submission. AGNJ's accreditation structure does not allow for inclusion of the FIDE SNP population in Medicaid HEDIS reporting.

Overall, most measures remained constant from MY 2021 to MY 2022 (< 5 percentage point change). Significant increases and decreases (≥ 5 percentage point change) in performance from MY 2021 are noted below. Due to the impact of the COVID-19 pandemic, caution should be exercised in interpreting year-over-year performance for the MCOs.

Improvements in performance from MY 2021 to MY 2022:

- Childhood Immunization (CIS)
  - Combination 7 improved by 6.03 percentage points.
- Asthma Medication Ratio (AMR)
  - 19–50 Years increased by 5.72 percentage points.
  - 51–64 Years increased by 8.77 percentage points.
- Appropriate Testing for Pharyngitis (CWP)
  - 65+ Years improved by 10.19 percentage points.

- Kidney Health Evaluation for Patients with Diabetes (KED)
    - 18–64 Years improved by 12.63 percentage points.
    - 65–74 Years improved by 11.50 percentage points.
    - 75–85 Years improved by 8.76 percentage points.
    - Total Rate improved by 12.29 percentage points.
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
    - 65+ Years – 30-Day Follow-Up improved by 9.36 percentage points.
    - 65+ Years – 7-Day Follow-Up improved by 10.03 percentage points.
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
    - 1–11 Years improved by 5.56 percentage points.

Decreases in performance from MY 2021 to MY 2022:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
    - Counseling for Nutrition – 3–11 Years decreased by 6.98 percentage points.
    - Counseling for Physical Activity – 3–11 Years decreased by 5.56 percentage points.
- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
    - 18–64 Years decreased by 5.58 percentage points.
    - 65+ Years decreased by 12.11 percentage points.
- Appropriate Treatment for Upper Respiratory Infection (URI)
    - 65+ Years decreased by 7.86 percentage points.
- Follow-Up After Hospitalization for Mental Illness (FUH)
    - 6–17 Years – 30-Day Follow-Up decreased by 7.11 percentage points.
    - 18–64 Years – 30-Day Follow-Up decreased by 6.29 percentage points.
    - Total – 30-Day Follow-Up decreased by 6.28 percentage points.

IPRO aggregated the MCO rates for the 40 measures included in the NJ Medicaid HEDIS grid and calculated weighted statewide averages to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. HEDIS rates produced by the MCOs were also reported to the NCQA. Complete audit review tables (ARTs) for each MCO are provided in **Appendix A: January 2023–December 2023 NJ MCO-Specific Review Findings.**

For this report, the MCOs' reported rates were compared to the NCQA HEDIS MY 2022 Quality Compass® national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA HEDIS MY 2022 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles (**Table 22**).

Table 22: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2022 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA HEDIS MY 20212Quality Compass National Percentiles
Red	Below 10th Percentile
Orange	Between 10th and 25th Percentile
Yellow	Between 25th and 50th Percentile
Green	Between 50th and 75th Percentile
Blue	Above 75th Percentile
Purple	No percentiles released by NCQA

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

HEDIS data presented in this section include: Effectiveness of Care, Overuse/Appropriateness, Access/Availability of Care, Utilization and Risk Adjusted Utilization, and Electronic Clinical Data System measures. **Table 23** displays the HEDIS PMs for MY 2022 for all MCOs and the NJ Medicaid Average. The Medicaid average is the weighted average of all MCO data.

Table 23: HEDIS MY 2022 Performance Measures

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Childhood Immunization (CIS)						
Combination 3	62.04%	61.31%	63.75%	54.99%	56.45%	61.78%
Combination 7	46.96%	47.20%	51.82%	44.53%	44.53%	49.45%
Combination 10	29.20%	30.90%	35.52%	33.33%	31.87%	33.86%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months (6 or more visits)	52.92%	54.68%	55.38%	52.43%	44.73%	54.33%
Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	70.48%	74.86%	71.53%	69.30%	67.12%	71.49%
Child and Adolescent Well-Care Visits (WCV)						
3 - 11 years	62.17%	68.45%	67.12%	65.29%	62.60%	66.56%
12 - 17 years	53.23%	61.41%	62.06%	60.44%	58.78%	61.20%
18 - 21 years	29.50%	39.03%	38.11%	38.90%	33.44%	37.86%
Total Rate	53.91%	61.42%	60.28%	59.08%	55.97%	59.77%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI percentile - 3-11 Years	86.52%	83.71%	84.24%	80.43%	83.40%	83.49%
BMI percentile - 12-17 Years	81.25%	85.03%	82.46%	86.36%	82.89%	83.56%
BMI percentile - Total	84.67%	84.18%	83.51%	82.97%	83.21%	83.53%
Counseling for Nutrition - 3-11 Years	81.65%	78.79%	77.58%	74.47%	81.85%	77.46%
Counseling for Nutrition - 12-17 Years	79.86%	79.59%	82.46%	79.55%	76.97%	81.25%
Counseling for Nutrition - Total	81.02%	79.08%	79.57%	76.64%	80.05%	78.99%
Counseling for Physical Activity - 3-11 Years	79.40%	76.52%	73.94%	68.51%	79.54%	73.67%
Counseling for Physical Activity - 12-17 Years	79.17%	77.55%	80.70%	76.70%	78.29%	79.36%
Counseling for Physical Activity - Total	79.32%	76.89%	76.70%	72.02%	79.08%	75.97%
Immunizations For Adolescents (IMA)						
Meningococcal	82.97%	89.54%	91.48%	86.77%	83.70%	89.63%
Tdap/Td	84.67%	93.67%	93.43%	89.71%	87.10%	92.10%
HPV	25.06%	31.39%	36.01%	31.29%	30.66%	33.82%
Combination 1	82.48%	89.05%	90.75%	85.59%	82.48%	88.82%
Combination 2	24.33%	29.44%	34.31%	30.08%	28.47%	32.22%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Lead Screening in Children (LSC)	70.32%	78.10%	68.09%	70.80%	72.02%	70.46%
Breast Cancer Screening (BCS)	45.11%	54.31%	57.51%	60.68%	57.71%	57.48%
Cervical Cancer Screening (CCS)	52.31%	59.69%	59.55%	59.25%	50.12%	58.63%
Chlamydia Screening (CHL)						
16-20 Years	59.41%	60.65%	54.80%	61.25%	65.70%	57.46%
21-24 Years	67.30%	60.21%	66.01%	65.46%	68.46%	65.27%
Total	64.20%	60.41%	60.24%	63.05%	67.23%	61.28%
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	60.53%	69.82%	75.67%	75.89%	64.91%	73.36%
45-64 Years	71.42%	78.36%	85.23%	85.89%	80.89%	83.53%
65+ Years	72.61%	78.68%	90.99%	93.30%	83.30%	90.31%
Total	64.44%	72.58%	79.51%	81.98%	71.82%	77.81%
Colorectal Cancer Screening (COL)[3]						
46-49 Years	12.46%	17.13%	22.17%	21.37%	15.14%	20.54%
50-75 Years	24.59%	34.57%	43.38%	51.06%	35.62%	42.84%
Total	22.30%	30.95%	39.33%	46.33%	32.38%	38.74%
Asthma Medication Ratio (AMR)						
5-11 Years	68.00%	76.25%	76.79%	63.91%	66.22%	73.05%
12-18 Years	68.06%	69.05%	73.11%	60.48%	65.08%	69.19%
19-50 Years	70.38%	62.86%	73.15%	59.29%	59.90%	68.78%
51-64 Years	75.34%	64.86%	77.47%	59.23%	57.72%	71.42%
Total	71.00%	66.70%	74.73%	60.26%	60.23%	70.13%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
3 months to 17 Years	65.36%	63.18%	60.21%	59.09%	56.14%	60.46%
18 to 64 Years	41.39%	38.99%	35.76%	38.90%	39.29%	37.17%
65+ Years	NA	40.00%	38.64%	31.28%	40.54%	35.26%
Total	58.97%	56.46%	52.31%	51.17%	50.37%	52.80%
Appropriate Treatment for Upper Respiratory Infection (URI)						
3 Months-17 Years	93.92%	93.52%	93.14%	92.42%	92.75%	93.08%
18-64 Years	68.76%	70.53%	65.41%	64.55%	61.06%	65.76%
65+ Years	67.68%	56.07%	54.82%	47.49%	60.47%	52.20%
Total	89.13%	89.70%	87.32%	85.59%	85.96%	87.34%
Appropriate Testing for Pharyngitis (CWP)						
3-17 Years	86.20%	84.88%	66.27%	80.62%	74.27%	74.14%
18-64 Years	48.00%	55.54%	38.60%	49.49%	33.41%	43.19%
65+ Years	NA	NA	26.10%	24.68%	8.33%	23.71%
Total	72.03%	76.02%	55.59%	70.96%	59.35%	63.23%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Hemoglobin A1c Control for Patients with Diabetes (HBD)[4]						
HbA1c Poor Control (> 9.0%)[5]	32.60%	36.74%	34.96%	28.47%	34.55%	33.46%
HbA1c Control (< 8.0%)	60.34%	53.28%	59.41%	61.80%	56.69%	59.33%
Eye Exam for Patients With Diabetes (EED)[4]	48.66%	49.64%	55.99%	62.53%	47.69%	56.16%
Blood Pressure Control for Patients With Diabetes (BPD)[4]	61.80%	58.39%	63.33%	72.99%	66.67%	65.29%
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 years	34.57%	33.87%	32.86%	36.36%	37.69%	34.01%
65–74 years	39.71%	38.76%	39.34%	43.78%	42.47%	41.56%
75–85 years	38.12%	34.76%	37.63%	38.36%	37.50%	37.90%
Total Rate	35.27%	34.17%	33.53%	38.20%	38.08%	35.06%
Controlling High Blood Pressure (CBP)	61.31%	63.02%	65.72%	67.88%	65.45%	65.80%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	79.55%	80.90%	84.12%	80.49%	65.31%	81.94%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
21-75 years (Male) - Received Statin Therapy	75.14%	82.18%	83.48%	82.78%	82.77%	82.73%
40-75 years (Female) - Received Statin Therapy	71.03%	76.18%	79.27%	76.75%	74.72%	77.68%
Total - Received Statin Therapy	73.62%	79.87%	81.66%	79.82%	79.17%	80.49%
21-75 years (Male) - Statin Adherence 80%	74.91%	72.76%	75.73%	76.51%	74.52%	75.56%
40-75 years (Female) - Statin Adherence 80%	67.11%	65.33%	76.32%	75.72%	68.42%	74.61%
Total - Statin Adherence 80%	72.13%	70.03%	75.98%	76.14%	71.95%	75.16%
Follow-Up After Emergency Department Visit for Substance Use (FUA)[6,7]						
13-17 years - 30 Day Follow-Up	NA	12.82%	22.96%	23.08%	NA	22.56%
13-17 years - 7 Day Follow-Up	NA	10.26%	15.19%	17.58%	NA	15.20%
18 and older - 30 Day Follow-Up	38.03%	35.01%	42.67%	37.09%	34.17%	40.15%
18 and older - 7 Day Follow-Up	27.27%	25.23%	31.47%	27.27%	24.76%	29.45%
Total - 30 Day Follow-Up	38.17%	34.53%	42.17%	36.64%	33.92%	39.73%
Total - 7 Day Follow-Up	27.27%	24.90%	31.05%	26.96%	24.51%	29.10%
Follow-Up After Hospitalization for Mental Illness (FUH)[6]						
6-17 years - 30-Day Follow-Up	44.90%	31.56%	45.00%	NA	42.47%	37.38%
6-17 years - 7-Day Follow-Up	26.53%	18.79%	10.00%	NA	19.18%	19.96%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
18-64 years - 30-Day Follow-Up	38.59%	27.44%	56.16%	51.51%	33.27%	37.28%
18-64 years - 7-Day Follow-Up	22.07%	16.48%	33.81%	32.97%	20.53%	22.47%
65+ years - 30-Day Follow-Up	NA	NA	43.90%	41.30%	NA	39.61%
65+ years - 7-Day Follow-Up	NA	NA	19.51%	23.91%	NA	21.43%
Total - 30-Day Follow-Up	38.93%	28.21%	53.95%	49.83%	34.38%	37.38%
Total - 7 Day Follow-Up	22.33%	16.90%	30.23%	31.36%	20.47%	22.12%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[6]						
6-17 years - 30-Day Follow-Up	69.55%	61.35%	72.49%	69.71%	54.07%	70.24%
6-17 years - 7-Day Follow-Up	63.18%	51.39%	62.96%	61.98%	45.93%	61.16%
18-64 years - 30-Day Follow-Up	61.93%	61.61%	62.47%	63.09%	61.12%	62.40%
18-64 years - 7-Day Follow-Up	53.35%	52.20%	54.33%	53.45%	53.16%	53.81%
65+ years - 30-Day Follow-Up	NA	NA	61.22%	63.64%	NA	64.24%
65+ years - 7-Day Follow-Up	NA	NA	48.98%	57.58%	NA	55.15%
Total - 30-Day Follow-Up	63.67%	61.73%	66.86%	65.77%	59.17%	65.65%
Total - 7 Day Follow-Up	55.48%	52.16%	58.09%	57.01%	51.00%	56.85%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1-11 Years	NA	46.15%	63.55%	67.03%	NA	62.50%
12-17 Years	51.16%	55.32%	71.98%	65.98%	73.33%	68.26%
Total	55.88%	52.85%	69.13%	66.27%	68.75%	66.41%
Use of Opioids at High Dosage (HDO)[5]	9.29%	10.26%	11.59%	10.12%	6.61%	10.92%
Use of Opioids From Multiple Providers (UOP)[5]						
Multiple Prescribers	19.52%	13.33%	17.59%	11.57%	11.54%	15.87%
Multiple Pharmacies	2.69%	1.12%	1.79%	1.28%	1.56%	1.66%
Multiple Prescribers and Multiple Pharmacies	1.79%	0.50%	0.77%	0.71%	0.87%	0.78%
Risk of Continued Opioid Use (COU)[5]						
18-64 years - >=15 Days covered	5.33%	2.70%	5.59%	5.87%	8.50%	5.45%
18-64 years - >=31 Days covered	3.48%	1.87%	3.43%	4.00%	4.49%	3.42%
65+ years - >=15 Days covered	16.30%	5.56%	11.94%	14.60%	21.36%	13.59%
65+ years - >=31 Days covered	5.43%	1.11%	7.17%	8.46%	8.74%	7.69%
Total - >=15 Days covered	5.61%	2.74%	5.77%	6.96%	8.97%	5.82%
Total - >=31 Days covered	3.53%	1.86%	3.53%	4.56%	4.64%	3.61%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	56.59%	62.38%	67.99%	70.47%	70.12%	67.68%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	88.21%	86.59%	80.01%	87.05%	89.02%	83.11%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing						
1-11 Years	22.64%	37.57%	22.90%	34.80%	32.56%	26.55%
12-17 Years	31.87%	42.29%	32.76%	44.23%	54.46%	36.60%
Total	28.47%	40.93%	29.65%	41.71%	47.92%	33.54%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	64.36%	60.36%	59.16%	63.50%	57.92%	60.36%
Effective Continuation Phase Treatment	47.91%	43.75%	44.32%	46.55%	42.79%	44.84%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	36.67%	35.02%	31.34%	39.51%	40.28%	33.95%
Continuation and Maintenance Phase	35.56%	36.75%	35.74%	42.64%	NA	37.60%
Initiation and Engagement of Substance Use Disorder Treatment (IET)[8]						
Alcohol - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Alcohol - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Other - 13-17 Years Initiation	NA	40.83%	NA	NA	20.00%	36.26%
Other - 13-17 Years Engagement	NA	5.00%	NA	NA	3.33%	5.49%
Total - 13-17 Years Initiation	36.11%	39.72%	NA	NA	18.42%	35.16%
Total - 13-17 Years Engagement	8.33%	4.96%	NA	NA	2.63%	5.02%
Alcohol - 18-64 Years Initiation	40.90%	42.51%	36.08%	47.98%	37.12%	40.97%
Alcohol - 18-64 Years Engagement	7.89%	8.19%	3.61%	7.62%	5.24%	7.21%
Opioid - 18-64 Years Initiation	70.34%	66.91%	41.30%	51.06%	62.30%	63.58%
Opioid - 18-64 Years Engagement	41.35%	35.25%	23.19%	18.44%	28.27%	33.04%
Other - 18-64 Years Initiation	47.36%	46.09%	36.63%	48.44%	43.07%	45.48%
Other - 18-64 Years Engagement	10.79%	9.45%	9.88%	11.11%	7.74%	9.60%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Total - 18-64 Years Initiation	49.27%	48.97%	37.70%	48.90%	44.93%	47.54%
Total - 18-64 Years Engagement	15.63%	14.31%	11.11%	11.54%	11.23%	13.64%
Alcohol - 65+ Years Initiation	NA	NA	48.00%	39.33%	NA	41.36%
Alcohol - 65+ Years Engagement	NA	NA	5.60%	3.77%	NA	3.90%
Opioid - 65+ Years Initiation	NA	NA	37.50%	38.83%	NA	38.80%
Opioid - 65+ Years Engagement	NA	NA	12.50%	10.68%	NA	12.94%
Other - 65+ Years Initiation	NA	NA	39.06%	40.00%	NA	39.46%
Other - 65+ Years Engagement	NA	NA	4.69%	6.67%	NA	5.41%
Total - 65+ Years Initiation	33.33%	43.33%	42.91%	39.37%	NA	40.27%
Total - 65+ Years Engagement	2.38%	6.67%	7.28%	6.04%	NA	6.52%
Alcohol - Total Years Initiation	40.64%	42.53%	40.75%	43.41%	36.47%	40.91%
Alcohol - Total Years Engagement	7.66%	8.05%	4.39%	5.62%	5.13%	6.82%
Opioid - Total Years Initiation	69.58%	66.38%	40.00%	45.90%	62.21%	61.05%
Opioid - Total Years Engagement	40.48%	35.04%	19.52%	15.16%	28.53%	30.97%
Other - Total Years Initiation	46.83%	45.58%	37.55%	45.48%	42.20%	44.71%
Other - Total Years Engagement	10.68%	9.05%	8.44%	9.64%	7.52%	9.19%
Total - Total Years Initiation	48.78%	48.55%	39.56%	44.66%	44.28%	46.64%
Total - Total Years Engagement	15.28%	13.87%	9.79%	9.14%	11.11%	12.84%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	82.73%	90.02%	79.63%	84.18%	79.81%	82.64%
Postpartum Care	81.51%	83.45%	78.89%	80.78%	78.83%	80.28%
Annual Dental Visit (ADV)						
2-3 Years	20.32%	35.01%	44.26%	47.46%	39.82%	41.54%
4-6 Years	35.80%	60.38%	62.47%	68.39%	56.61%	61.80%
7-10 Years	40.39%	65.07%	67.17%	72.23%	60.89%	66.62%
11-14 Years	36.83%	60.69%	64.61%	69.70%	56.61%	63.89%
15-18 Years	29.11%	51.82%	57.25%	61.84%	48.73%	56.27%
19-20 Years	18.93%	35.77%	41.82%	46.76%	31.31%	40.72%
Total	31.91%	54.60%	59.13%	64.48%	51.44%	58.15%
Ambulatory Care - Outpatient Visits per Thousand Member Years (AMB)[9]						
Total - Total Member Years	3546.83	4219.54	4717.86	5058.41	4422.89	4638.57
Ambulatory Care - Emergency Room Visits per Thousand Member Years (AMB)[9]						
Total - Total Member Years	519.61	444.04	640.49	542.37	501.79	582.09
Plan All-Cause Readmissions (PCR)[10]						
Index Stays per Year - 18-44	10.36%	10.42%	10.72%	10.21%	11.10%	10.62%
Index Stays per Year - 45-54	12.59%	12.65%	11.51%	10.53%	11.64%	11.54%

HEDIS MY 2022 Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP[1]	NJ Medicaid Average[2]
Index Stays per Year - 55-64	12.58%	14.47%	12.75%	12.64%	13.45%	12.94%
Index Stays per Year - Total	11.40%	12.06%	11.45%	11.02%	11.99%	11.47%
Observed-to-Expected Ratio	1.16	1.21	1.18	1.09	1.18	
ELECTRONIC CLINICAL DATA SYSTEMS						
Prenatal Immunization Status (PRS-E)						
Influenza	16.67%	15.63%	18.61%	17.25%	16.94%	17.61%
Tdap	38.51%	31.29%	37.31%	30.43%	29.72%	34.79%
Combination	12.82%	9.98%	12.76%	11.11%	10.04%	11.85%

[1] WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective 08/01/2023.
[2] New Jersey (NJ) Medicaid average is the weighted average of all managed care organization (MCO) data.
[3] Measurement year (MY) 2022 is the first year NJ is reporting this measure.
[4] For MY 2022, the former Comprehensive Diabetes Care (CDC) measure has been separated into three standalone measures: HBD, BPD, and EED.
[5] Higher rates for HBD HbA1c Poor Control, COU, HDO, and UOP indicate poorer performance.
[6] FUM requires medical and mental health benefits. FUH requires medical and mental health (inpatient and outpatient) benefits. FUA requires medical, chemical dependency and pharmacy benefits. All NJ Medicaid and fully integrated dual eligible special needs plan (FIDE SNP) members with full or partial behavioral health (BH) benefits were to be included.
[7] For MY 2022, the National Committee for Quality Assurance (NCQA) revised FUA terminology from "alcohol or other drug abuse or dependence (AOD)" to "substance use" or "substance use disorder (SUD)". Break in trending for all product lines due to significant changes to the measures during reevaluation.
[8] For MY 2022, IET indicators underwent major changes and are not comparable to the parent indicators in the IET measure in MY 2021. New indicator keys were issued and will not provide links back to the original IET indicators.
[9] For MY 2022, the eligible population for the AMB measure is the reported member years. Ambulatory measure rates are a measure of utilization rather than performance.
[10] PCR rate is based on observed count of 30-day readmission/count of index stays, and the rate is observed-to-expected ratio with risk adjustment. For PCR, a lower ratio indicates better performance.
Designation NA: For non-ambulatory measures, indicates that the MCO had a denominator less than 30. For ambulatory measures, indicates that the MCO had 0 member years in the denominator.
Designation NR: Indicates that the MCO did not report for the measure.
Designation CNC: Averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.
HEDIS: Healthcare Effectiveness Data and Information Set; BMI: body mass index; Tdap/Td: tetanus, diphtheria, and pertussis/ tetanus and diphtheria; HPV: human papillomavirus; ADHD: attention-deficit/hyperactivity disorder; HbA1c: hemoglobin A1c.

MY 2022 New Jersey State-Specific Performance Measures

The MCOs were required to report two (2) NJ-specific measures for their Medicaid population. The MCOs were required to provide member-level files for review and validation.

The required measures were:

- Preventive Dental Visit – The MCOs were required to report the rates for the total population, and for three subpopulations: Medicare/Medicaid Dual-Eligibles, Medicaid-Disabled, and Medicaid-Other Low Income.
- Multiple Lead Testing in Children Through 26 Months of Age

As the Preventive Dental Visit measure is not a HEDIS measure, the MCOs were required to submit the source code used to calculate the measure along with the rate submission. Prior to accepting the submission, IPRO validated that the submitted source code correctly calculated the rates for this measure. MCOs were given the opportunity to respond to any issues found in the source code and resubmit the rates if necessary.

Conclusions and Comparative Findings

1. For MY 2022, ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP included FIDE SNP dual members in the Preventive Dental Visit measure.
2. Overall performance for the Preventive Dental measure remained consistent with MY 2021 for all MCOs, with the exception of ABHNJ for which overall performance declined.
3. Overall performance for the Multiple Lead Testing in Children – Screening through 26 Months of Age measure remained consistent with MY 2021 for all MCOs, with the exception of HNJH for which screening between 9 and 18 months was significantly higher.

Table 24 shows state-specific PMs for MY 2022 for all MCOs and the NJ Medicaid average.

Table 24: MY 2022 NJ State-Specific Performance Measures

MY 2022 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP[1]	NJ Medicaid Average[2]
Preventive Dental Visit (NJD)						
Total - 1 Year	3.74%	9.32%	15.63%	16.90%	21.82%	14.19%
Total - 2-3 Years	19.67%	34.38%	41.37%	46.60%	39.39%	39.58%
Total - 4-6 Years	33.10%	58.57%	59.41%	66.80%	55.03%	59.30%
Total - 7-10 Years	36.92%	62.30%	63.89%	70.30%	58.45%	63.70%
Total - 11-14 Years	32.34%	56.82%	59.77%	66.47%	53.71%	59.59%
Total - 15-18 Years	23.23%	46.69%	50.00%	57.04%	44.78%	49.96%
Total - 19-21 Years	14.81%	29.83%	33.70%	40.15%	25.17%	33.30%
Total - 22-34 Years	12.85%	23.67%	30.06%	34.00%	19.26%	27.82%
Total - 35-64 Years	14.64%	25.99%	30.49%	33.98%	24.33%	29.37%
Total - 65+ Years	13.88%	23.99%	25.87%	26.72%	25.66%	25.57%
Total - Total	18.91%	36.22%	40.69%	45.23%	31.60%	39.44%
Dual Eligibles - 1 Year	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 2-3 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 4-6 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 7-10 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 11-14 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 15-18 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 19-21 Years	NA	23.40%	38.73%	44.58%	NA	CNC
Dual Eligibles - 22-34 Years	18.83%	24.90%	34.63%	35.74%	27.69%	33.04%
Dual Eligibles - 35-64 Years	23.03%	28.98%	34.22%	36.10%	29.65%	33.74%
Dual Eligibles - 65+ Years	16.00%	25.09%	27.09%	27.51%	28.46%	26.84%
Dual Eligibles - Total	18.38%	26.19%	29.78%	30.29%	28.65%	29.20%
Disabled - 1 Year	NA	6.25%	16.41%	6.06%	NA	12.79%
Disabled - 2-3 Years	24.32%	33.33%	43.42%	50.00%	34.43%	41.86%
Disabled - 4-6 Years	22.79%	49.87%	54.67%	61.13%	44.97%	54.03%
Disabled - 7-10 Years	25.89%	49.26%	58.72%	60.64%	39.47%	56.64%
Disabled - 11-14 Years	20.79%	50.46%	54.29%	54.32%	35.81%	52.55%
Disabled - 15-18 Years	23.94%	36.90%	44.54%	48.24%	32.73%	43.94%
Disabled - 19-21 Years	9.85%	25.04%	33.45%	37.87%	17.24%	31.92%
Disabled - 22-34 Years	13.12%	23.76%	32.26%	32.33%	21.33%	29.81%
Disabled - 35-64 Years	15.56%	24.57%	27.20%	28.41%	25.17%	26.68%
Disabled - 65+ Years	12.30%	14.88%	18.20%	17.95%	19.69%	17.50%
Disabled - Total	15.53%	27.50%	33.82%	34.85%	24.15%	32.04%

MY 2022 NJ-Specific Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP[1]	NJ Medicaid Average[2]
Other Low Income - 1 Year	3.77%	9.33%	15.62%	16.97%	22.01%	14.20%
Other Low Income - 2-3 Years	19.60%	34.40%	41.33%	46.54%	39.47%	39.54%
Other Low Income - 4-6 Years	33.33%	58.75%	59.58%	66.98%	55.34%	59.46%
Other Low Income - 7-10 Years	37.26%	62.66%	64.11%	70.73%	59.10%	63.98%
Other Low Income - 11-14 Years	32.68%	57.03%	60.03%	67.05%	54.40%	59.91%
Other Low Income - 15-18 Years	23.21%	47.06%	50.26%	57.52%	45.28%	50.24%
Other Low Income - 19-21 Years	14.99%	30.10%	33.69%	40.28%	25.75%	33.36%
Other Low Income - 22-34 Years	12.80%	23.62%	29.81%	34.05%	19.07%	27.55%
Other Low Income - 35-64 Years	14.36%	25.68%	30.46%	34.27%	23.98%	29.14%
Other Low Income - 65+ Years	10.70%	16.57%	21.31%	24.62%	19.72%	20.46%
Other Low Income - Total	19.08%	38.06%	42.19%	49.03%	32.58%	41.13%
Multiple Lead Testing in Children through 26 Months of Age (MLT)						
Screening between 9 Months and 18 Months	58.50%	66.94%	53.56%	60.34%	64.71%	57.51%
Screening at 18 Months through 26 Months	40.83%	48.62%	40.86%	43.17%	48.54%	42.80%
Screening between 9 Months and 18 Months AND Screening at 18 Months through 26 Months	29.82%	37.38%	25.25%	29.58%	36.82%	28.66%

[1] WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective 08/01/2023.
[2] New Jersey (NJ) Medicaid average is the weighted average of all managed care organization (MCO) data.
Designation NA: Indicates that MCO had a denominator less than 30.
Designation CNC: An unweighted average can only be calculated if 2 or more MCOs have a reportable rate.
MY: measurement year.

MY 2022 New Jersey Core Set Performance Measures

DMAHS requested the MCOs to submit thirteen (13) Core Set Measures in MY 2022:

Seven Child Core Set Measures were reported:

1. Developmental Screening in The First Three Years of Life (DEV-CH)
2. Contraceptive Care Postpartum Women Ages 15-20 (CCP-CH)
3. Contraceptive Care All Women Ages 15-20 (CCW-CH)
4. Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
5. Preventive Oral Evaluation, Dental Services (OEV-CH)
6. Topical Fluoride for Children (TFL-CH)
7. Sealant Receipt on Permanent First Molars (SFM-CH)

Six Adult Core Set Measures were reported:

1. Diabetes Short-Term Complications Admission Rate (PQI01-AD)
2. Contraceptive Care Postpartum Women Ages 21-44 (CCP-AD)
3. Contraceptive Care All Women Ages 21-44 (CCW-AD)
4. Screening for Depression and Follow-up Plan: Ages 18 to 64 and Ages 65 and Older (CDF-AD)
5. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (HPCMI-AD)
6. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)

The changes from MY 2021 to MY 2022 were:

1. The following measures were added:
    a. Preventive Oral Evaluation, Dental Services (OEV-CH)
    b. Topical Fluoride for Children (TFL-CH)
    c. Sealant Receipt on Permanent First Molars (SFM-CH)
    d. Screening for Depression and Follow-up Plan: Ages 18 to 64 and Ages 65 and Older (CDF-AD)
    e. Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (> 9.0%) (HPCMI-AD)
    f. Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)
2. Contraceptive Care – Postpartum Women Ages 15-20 and Ages 21-44: the check for methods of contraception was updated to within 3 and 90 days of delivery.

Conclusions and Comparative Findings

Significant year-over-year improvements were seen in certain submeasures of the CCP measure for all MCOs. HNJH demonstrated significant improvement in PQI01-AD over MY 2021. All other measures remained consistent with MY 2021 performance.

Table 25 shows the NJ Core Set Measures for MY 2022 for all MCOs and the NJ Medicaid average.

Table 25: MY 2022 NJ Core Set Measures

MY 2022 NJ Core Set Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP[1]	NJ Medicaid Average[2]
Developmental Screening (DEV-CH)						
1 year old	32.80%	26.56%	43.47%	31.26%	33.05%	37.72%
2 years old	49.15%	57.03%	51.01%	41.98%	42.70%	50.40%
3 years old	43.65%	51.61%	45.35%	39.97%	37.96%	44.94%
Total - 1-3 years	43.08%	47.13%	47.00%	38.57%	38.89%	45.15%
Diabetes Short-Term Complications Admission (PQI01) - Admissions per 100,000 Member Months[3]						
18 - 64 Years	5.94	7.45	17.85	10.80	11.52	14.06
65 Years and Older	2.26	10.96	7.91	11.88	12.57	10.26
Total	5.74	7.78	17.48	10.96	11.66	13.78
Contraceptive Care - Postpartum Women (CCP)[4]						
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 3 days	5.26%	0.98%	3.58%	2.56%	5.26%	3.30%
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 90 days	31.58%	40.20%	40.11%	36.41%	42.11%	39.08%
Postpartum Women Ages 15-20 - LARC - 3 days	1.75%	0.00%	0.00%	0.00%	2.63%	0.18%
Postpartum Women Ages 15-20 - LARC - 90 days	5.26%	4.90%	8.31%	5.64%	7.89%	7.34%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 3 days	6.05%	4.66%	9.51%	7.45%	5.71%	7.81%

MY 2022 NJ Core Set Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP[1]	NJ Medicaid Average[2]
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 90 days	38.99%	39.97%	40.18%	42.90%	39.09%	40.45%
Postpartum Women Ages 21-44 - LARC - 3 days	0.23%	0.14%	0.17%	0.00%	0.43%	0.15%
Postpartum Women Ages 21-44 - LARC - 90 days	9.22%	9.14%	8.18%	9.18%	8.99%	8.64%
Contraceptive Care - All Women (CCW)						
All Women Ages 15-20 - Provision of most or moderately effective contraception	13.38%	11.80%	15.17%	12.24%	10.67%	13.91%
All Women Ages 15-20 - Provision of LARC	0.95%	0.93%	1.08%	0.79%	0.50%	0.98%
All Women Ages 21-44 - Provision of most or moderately effective contraception	20.81%	23.42%	22.89%	21.87%	17.73%	22.28%
All Women Ages 21-44 - Provision of LARC	2.43%	3.03%	2.64%	2.79%	2.01%	2.65%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)						
12-17 Years	1.11%	2.70%	1.75%	1.52%	1.33%	1.78%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)[5]						
18 to 64 Years	3.04%	4.44%	4.96%	3.92%	5.61%	4.61%
65 Years and older	3.95%	6.87%	8.18%	9.00%	11.36%	8.43%
Oral Evaluation, Dental Services (OEV-CH)[5]						
< 1 Year	0.08%	0.83%	0.95%	1.23%	1.16%	0.92%
1 to 2 Years	8.52%	16.60%	24.72%	23.39%	25.37%	22.01%
3 to 5 Years	27.02%	47.90%	52.54%	54.87%	46.18%	50.54%
6 to 7 Years	31.11%	56.98%	61.42%	63.42%	52.24%	59.37%
8 to 9 Years	32.40%	57.73%	61.62%	63.78%	54.75%	60.02%
10 to 11 Years	30.33%	55.79%	60.31%	62.24%	52.21%	58.59%
12 to 14 Years	28.14%	52.03%	56.98%	60.04%	49.37%	55.58%
15 to 18 Years	20.85%	44.00%	48.19%	52.20%	41.34%	47.25%
19 to 20 Years	13.30%	29.00%	32.89%	37.80%	25.02%	32.25%
Total: <1 to 20 Years	22.82%	44.21%	49.61%	53.24%	42.60%	48.04%
Topical Fluoride for Children (TFL-CH)[5]						
1 to 2 Years	5.03%	13.99%	12.48%	14.66%	16.33%	12.68%
3 to 5 Years	1.73%	23.07%	24.23%	29.12%	21.94%	23.69%
6 to 7 Years	0.57%	25.77%	27.33%	32.26%	23.25%	26.77%
8 to 9 Years	0.61%	25.56%	26.39%	32.79%	23.73%	26.47%
10 to 11 Years	0.44%	22.93%	25.24%	30.37%	20.76%	24.91%
12 to 14 Years	0.23%	19.33%	21.69%	27.13%	18.63%	21.65%
15 to 18 Years	0.10%	10.73%	13.64%	17.31%	10.90%	13.50%
19 to 20 Years	0.00%	2.38%	4.27%	6.04%	2.10%	4.14%
Total: 1 to 20 Years	1.29%	18.27%	19.54%	24.21%	17.23%	19.42%

MY 2022 NJ Core Set Performance Measures	ABHNJ	AGNJ	HNJH	UHCCP	WCHP[1]	NJ Medicaid Average[2]
Sealant Receipt on Permanent First Molars (SFM_CH)[5]						
Rate 1 (At Least One Sealant)	23.78%	20.32%	7.59%	37.86%	46.62%	17.33%
Rate 2 (All Four Molars Sealed)	14.40%	10.76%	4.09%	22.42%	31.06%	9.99%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[3,5]						
18 to 64 Years	56.13%	53.57%	51.66%	45.40%	52.78%	50.65%
65 to 75 Years	NA	60.76%	43.20%	53.47%	40.00%	51.31%
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD): Ages 18 to 64[5]						
Total rate (Rate 1)	69.70%	64.79%	41.83%	46.09%	56.20%	60.20%
Buprenorphine (Rate 2)	48.68%	44.94%	25.49%	27.66%	37.37%	40.76%
Oral naltrexone (Rate 3)	1.82%	2.02%	1.17%	1.60%	2.34%	1.91%
Long-acting, injectable naltrexone (Rate 4)	3.06%	1.91%	0.39%	0.40%	2.54%	2.01%
Methadone (Rate 5)	25.25%	22.72%	16.54%	19.64%	21.17%	22.10%

[1] WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective 8/1/2023.
[2] New Jersey Medicaid average is the weighted average of all MCO data.
[3] Higher rates for PQI-O1 and HPCMI-AD indicate poorer performance.
[4] For CCP, the CMS Core Set specifications for MY 2022 were updated to check for methods of contraception within 3 and 90 days of delivery from contraception within 3 and 60 days of delivery during MY 2021.
[5] MY 2022 is the first year NJ is reporting this measure.
Designation N/A: the plan had less than 30 members in the denominator.
Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

WYE 2021 MLTSS Performance Measures

The MLTSS contract year runs July–June of WYE 2021 (July 1, 2020–June 30, 2021). Specifications were updated in 2020 for the July 2020–June 2021 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. Except for PM #04, which is reported monthly, PMs are reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*). PM 20a (*New MLTSS Members with MLTSS Services Within 120 Days of Enrollment - Assesses the number of unique new MLTSS members receiving MLTSS services within 120 days of enrollment. Reported annually*) was retired in 2021.

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2021 (7/1/20-6/30/21):

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.
3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.

7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
24. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
25. PM #46 – MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services
26. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
27. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
28. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
29. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
30. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
31. PM #52* – Care for Older Adults for HCBS MLTSS Members (HEDIS COA)
    a. 52a Advance care planning – HCBS
    b. 52b Medication review – HCBS
    c. 52c Functional status assessment – HCBS
    d. 52d Pain assessment – HCB
32. PM 53* – Care for Older Adults for NF MLTSS Members (HEDIS COA)
    a. 53a Advance care planning – NF
    b. 53b Medication review – NF
    c. 53c Functional status assessment – NF
    d. 53d Pain assessment – NF
33. PM #54* – New MLTSS members receiving PCA, MDC and/or MLTSS services.
    (This measure replaced PM #20a)

Validation Results of WYE 2021 MLTSS Performance Measures

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

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2024, IPRO produced an annual report which detailed the annual validation process and results, as well as the results of the monitoring activities. This report also provided annual rates for the July 2020–June 2021 measurement period.

The following results are for the July 2020 through June 2021 measurement period:

- PM #04: Timeliness of NF Level of Care Assessment by MCO: MCO rates all dropped to 0% due to the suspension of in-person care management activities due to the statewide impact of the COVID-19 pandemic.
- PM #18: Critical Incident Reporting:
  - [Rate A – Percent of Critical Incidents (CIs) that the managed care plan (MCP) became aware of during the measurement period that were reported to the State at the Total and Category level] MCP rates ranged from 99.8% to 100%, and the statewide rates remained steady between 99.9% to 100%.
  - [Rate B – Percent of CIs that the MCP became aware of during the measurement period that were reported by the MCP to the State within 2 business days at the Total and Category level] MCP rates ranged from 88.3% to 100%, and the statewide rates remained steady between 93.6% to 96.6%.
  - [Rate C – Percent of CIs that the MCP became aware of during the measurement period for which a date of occurrence was available at the Total and Category level] MCP rates ranged from 94.8% to 100%, and the statewide rates remained steady between 97.3% to 98.7%.
  - [Rate D – The average number of days from the date of occurrence for CIs in the Numerator of Rate C to the date the MCP became aware of the CI at the Total and Category level] The average days ranged from 7.8 days to 41.3 days for the MCP to be aware of the CI. At the statewide level, it took on average from 13.9 to 16.5 days throughout the MY.
- PM #20: MLTSS Members Receiving MLTSS Services: The quarterly MCP rates vary from 60.4% to 78.8%. The statewide rates remained steady between 71.8% to 72.8%.
- PM #20B: MLTSS HCBS Members Receiving MLTSS Services: The quarterly MCP rates vary from 39.6% to 69.2%. The statewide rates remained steady between 58.1% to 58.6%.
- PM #21: MLTSS Members Transitioned from NF to Community: The quarterly MCP rates remain low, from 0.3% to 1.6%, and the statewide rates vary from 0.8% to 1.1%.
- PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days: The MCP rates vary from 0% to 30%. The statewide rates range from 4.6% to 11.6%. However, most of the reported quarterly denominators are less than 30.
- PM #26: Acute Inpatient Utilization by MLTSS HCBS Members: The quarterly MCP rates vary from 21 to 63.1 utilization per 1000 member months, and the statewide rates range from 37.3 to 40.7 utilization per 1000 member months.
- PM #27: Acute Inpatient Utilization by MLTSS NF Members: The quarterly rates vary from 16.1 to 56.8 utilization per 1000 member months, and the statewide rates range from 33 to 36.4 utilization per 1000 member months.
- PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days: The quarterly rates range from 14.6% to 36% and the statewide rates vary from 18.6% to 22.5%.

- PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days: The quarterly rates range from 7.1% to 42.4% and the statewide rates vary from 17.8% to 25.3%.
- PM #30: Emergency Department Utilization by MLTSS HCBS Members: The quarterly rates vary from 30.9 to 84.4 utilization per 1000 member months, and the statewide rates stay relatively stable, from 50.6 to 63.1 utilization per 1000 member months.
- PM #31: Emergency Department Utilization by MLTSS NF Members: The quarterly rates vary from 2.2 to 19.3 utilization per 1000 member months, and the statewide rates stay relatively stable, from 8.9 to 9.6 utilization per 1000 member months.
- PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members:
  - [PM #33 PCA used only] the quarterly rates ranges from 6.1% to 18.9%, and the statewide rates stayed stable between 14.1% to 14.7%.
  - [PM #34 Medical Day used only] the quarterly rates ranges from 1% to 25%, and the statewide rates stayed stable between 7.3% to 7.6%.
  - [PM #41 PCA and Medical Day used only] the quarterly rates ranges from 2.2% to 14.5%, and the statewide rates stayed stable between 6.6% to 7%.
- PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members: The quarterly rates ranges from 21.4% to 80%. The statewide rates range from 42.6% to 51.6%. However, most of the reported quarterly denominators are less than 30.
- PM #38: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members: The quarterly rates ranges from 0% to 100%. The statewide rates range from 0% to 100%. However, most of the reported quarterly denominators are 0 or less than 10.
- PM #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS HCBS Members: The quarterly rates ranges from 0% to 45.5%. The statewide rates vary from 15.3% to 26.2%. However, most of the reported quarterly denominators are less than 10.
- PM #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for MLTSS NF Members: The quarterly rates ranges from 0% to 50%. The statewide rates vary from 0% to 16.7%. However, most of the reported quarterly denominators are 0 or less than 10.
- PM #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members: The quarterly rates ranges from 0% to 100%. The statewide rates are relatively stable, varying between 56.3% to 71.7%. However, most of the reported quarterly denominators 20.
- PM #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members: The quarterly rates ranges from 0% to 100%. The statewide rates are relatively stable, varying between 0% to 66.7%.However, most of the reported quarterly denominators are 0 or less than 10.

WYE 2022 MLTSS Performance Measures

The MLTSS contract year runs from July–June of WYE 2022 (July1 2021–June 30, 2022). Specifications were updated in 2021 for the July 2020–June 2021 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. Except for PM #04, which is reported monthly, PMs are reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*). PM 20a was retired in 2021.

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2022 (7/1/21-6/30/22):

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.

3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
24. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
25. PM #46 – MLTSS HCBS Members not receiving MLTSS HCBS, PCA or Medical Day Services
26. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
27. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
28. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
29. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
30. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
31. PM #52* Care for Older Adults for HCBS MLTSS Members (HEDIS COA)
    a. 52a Advance care planning – HCBS
    b. 52b Medication review – HCBS
    c. 52c Functional status assessment – HCBS
    d. 52d Pain assessment – HCB
32. PM 53* Care for Older Adults for NF MLTSS Members (HEDIS COA)
    a. 53a Advance care planning – NF
    b. 53b Medication review – NF
    c. 53c Functional status assessment – NF

d. 53d Pain assessment – NF
33. PM #54* New MLTSS members receiving PCA, MDC and/or MLTSS services. (This measure replaced PM #20a)

Validation Results of WYE 2022 MLTSS Performance Measures

The final validation report for WYE 2022 is in progress and will be reflected in next year's ATR.

WYE 2023 MLTSS Performance Measures

Specifications were updated in 2022 for the July 2022–June 2023 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. PM #04 was reported on a monthly basis. Three HEDIS measures and two MLTSS-specific measures (PM #47 and PM #54) were reported annually. All other PMs were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2023 (7/1/22-6/30/23):

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.
3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)

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

Validation Results of WYE 2023 MLTSS Performance Measures

The final validation report for WYE 2023 is in progress and will be reflected in next year's ATR.

WYE 2021 MLTSS Performance Measure #13

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

- Adult Family Care,
- Assisted Living Services/Program,
- Chore Services,
- Community Residential Services,
- Home Delivered Meals,
- Medical Day Services,
- Medication Dispensing Device Monthly Monitoring,
- Personal Care Assistance (PCA)/Home Based Supportive Care,
- Personal Emergency Response System (PERS) Monitoring, and
- Private Duty Nursing.

For WYE 2021, the validation of PM #13 for measurement period from July 2020 to June 2021 continued. For the July 2020–June 2021 measurement period, members were required to be enrolled in MLTSS HCBS with the MCO between July 1, 2020, and June 30, 2021.

For the July 2020–June 2021 measurement period, samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The final PM #13 reports were submitted to DMAHS in June 2023.

Plan of Care Services Assessed

The list of MLTSS services assessed in this methodology is presented in **Table 26**. MLTSS services were identified in the *MLTSS Services Dictionary*. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services.

Table 26: MLTSS Assessment Inclusion Status

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

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

PM #13 does not assess delivery of MLTSS HCBS services that are not delivered on a routine basis, such as respite care. Respite 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, yet the service is typically documented in the POC as 30 days per year. Respite 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,[2] and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC.

MLTSS services are often provided on a weekly schedule that is customized for the member's needs; for instance, a member may require 16 units of PCA service per day on weekdays, but only 8 units per day on

[2] The timeline of expected services was structured on a monthly basis for PERS services and Monthly Monitoring of Medication Dispensing Device services. For all other services, the timeline was structured on a weekly basis.

weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis; the cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday, and any incomplete weeks were dropped from the timeline of expected services. For example, PCA services from July 1, 2020 (Wednesday), to July 31, 2020 (Friday), were broken down into 4 complete weeks (i.e., week 1 was July 1 to July 7, . . . week 4 was July 22 to July 28), and the final incomplete week of July 29 to July 31 was dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline.

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

IPRO validated the member-level roll-up file, which showed services provided based on claims for each week in the review period, against the MCOs' claims systems during a review meeting with each MCO. For each service, the timelines were compared to assess the percentage of service delivery for each week/month. The percentage of service delivery could never exceed 100% for any given week/month. Where claims indicated that more than 100% of the expected service units were delivered, the percentage was capped at 100%. This strategy was applied so that, in aggregating services over a span of weeks, claims in excess of expected services in one particular week would not offset deficiencies in delivery of expected services in another week.

Compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must score at or above 95% for each service documented in the POC for each member.

Performance Measure Results

As shown in **Table 27**, a total of 89 records were excluded, resulting in a study population of 461 members across all plans. Records could be excluded for a number of reasons, including no POC submitted in the file, POCs submitted did not have the necessary information to produce quantifiable expected services, and POCs documented only services that were not evaluated for this measure (e.g., Respite Care or Personal Preference Program).

The total study population is 461, a decrease of 16 cases from the 477 cases included in the prior year's measure. Among the MCOs, Aetna's study population increased the most by 10 cases, from 89 in the previous year to 99 in the current year; United's study population decreased the most 23 cases, dropping from 89 to 66. United had the lowest sample size due to the high number of cases with no POC. United had 44 members with no POC submitted in the file (data not shown).

Table 27: Results Summary

MCO	Total Sampled	Current Year (2021)		Prior Year (2019)		Change in Study Population from Prior Year
		Total Excluded	Study Population	Total Excluded	Study Population	
Aetna	110	11	99	21	89	10
Amerigroup	110	12	98	12	98	0
Horizon	110	17	93	13	97	-4
United	110	44	66	21	89	-23
WellCare	110	5	105	6	104	1
Total	550	89	461	73	477	-16

MCO: Managed Care Organization.

Table 28 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 28.9%, a decrease of 7.8 percentage points from the rate of 36.7% for the prior year. It is observed that Amerigroup demonstrated better performance this year: Amerigroup's compliance rate increased by 3.1 percentage points to 29.6%. Among the MCOs, United had the lowest compliance rate of 16.7% and decreased the most from prior year. United's compliance rate decreased by 29.4 percentage points from 46.1% in the previous year to 16.7% in the current year. WellCare achieved the highest compliance rate, with a rate of 36.2%.

As noted above, compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must score at or above 95% for each service documented in the POC for each member. Of the 461 total members in the denominator, 133 (28.9%) received, on average, 95% of the planned service amount for all services documented in the POC.

Table 28: Compliance Rates

MCO	Current Year (2021)			Prior Year (2019)			Change in Rate from Prior Year
	Denominator	Numerator	Compliance Rate	Denominator	Numerator	Compliance Rate	
Aetna	99	30	30.3%	89	34	38.2%	-7.9%
Amerigroup	98	29	29.6%	98	26	26.5%	3.1%
Horizon	93	25	26.9%	97	37	38.1%	-11.2%
United	66	11	16.7%	89	41	46.1%	-29.4%
WellCare	105	38	36.2%	104	37	35.6%	0.6%
Total	461	133	28.9%	477	175	36.7%	-7.8%

MCO: Managed Care Organization.

Table 29 shows compliance at the service level for the individual MCOs, while **Table 30** shows compliance at the service level across all plans. The denominators displayed in **Table 29** and **Table 30** are the number of members who had the indicated service documented in their POC during the measurement period, while the numerators are the number of members whose average service delivery was above the 95% threshold. Note that a member can be represented in more than one service.

Across all plans, the most common MLTSS Service was PERS Monitoring; of the 248 members who had PERS Monitoring services planned, 101 (40.7%) received, on average, 95% or more of the planned amount. Of the MLTSS Services listed, Medical Day Services was associated with the highest proportion of members reaching the 95% average threshold; of the 150 members who had Medical Day Services planned, 113 (75.3%) received, on average, at least 95% of the planned amount.

For services with a denominator greater than or equal to 10 in **Table 30**, improvement was seen over the prior year only for the Medical Day Services. Rates with a denominator less than 10 are listed for reference only. Rates for services for which the denominator is small should be reviewed with caution. For rates across all plans, the compliance rate of Medical Day Services with a denominator of more than 10 increased the most, showing an increase of 44.6 percentage points from 30.7% in the prior year to 75.3% in the current year; the performance of PERS Monitoring improved the least, showing a decrease of 26.0 percentage points from 66.7% in the prior year to 40.7% in the current year.

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

	Aetna				Amerigroup				Horizon				United				WellCare			
Services Evaluated	D	N	2021 %	2019 %	D	N	2021 %	2019 %	D	N	2021 %	2019 %	D	N	2021 %	2019 %	D	N	2021 %	2019 %
Adult Family Care																				
Assisted Living Services/Programs	12	10	83.3%	66.7%	8	7	87.5%[a]	71.4%[a]	21	13	61.9%[b2]	80.0%	3	2	66.7%[a]	83.3%	4	2	50.0%[a]	100%[a]
Chore Services																				
Community Residential Services									2	0	0.0%[a]									
Home Delivered Meals	8	5	62.5%[a]	42.9%	41	12	29.3%	26.9%	36	12	33.3%	59.4%	22	6	27.3%	65.4%	21	4	19.0%	66.7%
Medical Day Services	64	52	81.3%	6.7%	9	7	77.8%[a]	13.6%	11	4	36.4[b3]	25.0%	7	5	71.4%[a]	30.0%	59	45	76.3%	43.9%
Medication Dispensing Device Monthly Monitoring				0.0%[a]	2	0	0.0%[a]	100%[a]	2	0	0.0%[a]		1	0	0.0%[a]		1	0	0.0%[a]	0.0%[a]
PCA/Home Based Supportive Care	44	11	25.0%	43.5%	59	17	28.8%[b1]	30.8%	40	8	20.0%	47.3%	48	12	25.0%	50.0%	53	25	47.2%	56.3%
PERS Monitoring	49	2	4.1%	74.4%	66	49	74.2%	71.9%	53	22	41.5%	67.2%	21	0	0.0%	59.5%	59	28	47.5%	59.3%
Private Duty Nursing								0.0%[a]				33.3%[a]	1	0	0.0%[a]	40.0%[a]				0.0%[a]

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

[b1] Both Denominator and Numerator decreased this year: for PCA/Home Based Supportive Care, the Denominator decreased from 65 to 59 and the Numerator decreased from 20 to 17.

[b2] Both Denominator and Numerator increased this year: the Denominator increased from 10 to 21 and the Numerator increased from 8 to 13. However, there is no statistically significant difference between the 2021 and 2019 rates.

[b3] Both Denominator and Numerator decreased this year: the Denominator decreased from 24 to 11 and the Numerator decreased from 6 to 4. However, there is no statistically significant difference between the 2021 and 2019 rates.

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

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

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

Services Evaluated	All Plans						
	2021			2019			Change from 2019
	D	N	%	D	N	%	
Adult Family Care							
Assisted Living Services/Programs	48	34	70.8%	55	42	76.4%	-5.6%
Chore Services							
Community Residential Services	2	0	0.0%[a]				
Home Delivered Meals	128	39	30.5%	120	62	51.7%	-21.2%
Medical Day Services	150	113	75.3%	137	42	30.7%	44.6%
Medication Dispensing Device Monthly Monitoring	6	0	0.0%[a]	3	1	33.3%[a]	-33.3%
PCA/Home Based Supportive Care	244	73	29.9%	270	121	44.8%	-14.9%
PERS Monitoring	248	101	40.7%	249	166	66.7%	-26.0%
Private Duty Nursing	1	0	0.0%[a]	10	3	30.0%	-30.0%

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

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

Gray shading: Zero denominator for the Service, so numerator and rate is not applicable.

WYE 2022 MLTSS Performance Measure #13

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

In 2023, As per discussions with DMAHS, the validation of PM #13 measurement period was modified to August 2021 to June 2022 to coincide with the State guidance for Phase I-Return to Field for MLTSS members, a directive in response to the impact of the Covid-19 pandemic. For the measurement period August 2021 to June 2022, members were required to be enrolled in MLTSS HCBS with the MCO between August 15, 2021, and June 30, 2022.

For the measurement period (August 2021 to June 2022) samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The final PM #13 reports were submitted to DMAHS in February 2024.

Plan of Care Services Assessed

The list of MLTSS Services assessed in this methodology is presented in **Table 31**. MLTSS Services were identified in the *MLTSS Services Dictionary*. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services.

Table 31: MLTSS Assessment Inclusion Status

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

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

Performance Measure Methodology

Service data from the POCs were used to construct a timeline of expected services for each recurring service in the POC. The timeline of 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.

MLTSS Services are often provided on a weekly schedule that is customized for the Member's needs; for instance, a Member may require 16 units of Personal Care Assistant (PCA) service per day on weekdays, but only 8 units per day on weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis; the cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday,

and any incomplete weeks were dropped from the timeline of expected services. For example, PCA services from September 1, 2021 (Wednesday) to September 30, 2021 (Thursday) were broken down into 4 complete weeks (i.e., week 10 was September 2 to September 8, . . . week 13 was September 23 to September 29). The first incomplete week of September 1 and final incomplete week of September 30 were dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline.

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

IPRO validated the member-level roll-up file, which showed services provided based on claims for each week in the review period, against the MCOs' claims systems during a review meeting with each MCO. For each service, the timelines were compared to assess the percentage of service delivery for each week/month. The percentage of service delivery could never exceed 100% for any given week/month. Where claims indicated that more than 100% of the expected service units were delivered, the percentage was capped at 100%. This strategy was applied so that, in aggregating services over a span of weeks, claims in excess of expected services in one particular week would not offset deficiencies in delivery of expected services in another week.

Compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must score at or above 95% for each service documented in the POC for each member.

Performance Measure Results

As shown in **Table 32,** a total of 101 records were excluded, resulting in a study population of 449 members across all plans. Records could be excluded for several reasons; including no POC submitted in the file, POCs submitted did not have the necessary information to produce quantifiable expected services, and POCs contained only documented services that were not evaluated for this measure (e.g., Respite Care or Personal Preference Program).

The total study population was 449, a decrease of 12 cases from the 461 cases included in the prior year's measure (**Table 32**). Among the MCOs, United's study population increased the most by 8 cases, from 66 in the previous year to 74 in the current year; Amerigroup's and Fidelis Care's study populations decreased the most by 9 cases, dropping from 98 in the previous year to 89 in the current year and 105 in the previous year to 96 in the current year, respectively. Among the MCOs, United had the lowest sample size of 74 cases in the current year (**Table 32**).

Table 32: Results Summary

MCO	Total Sampled	Current Year (2022)		Prior Year (2021)		Change in Study Population from Prior Year
		Total Excluded	Study Population	Total Excluded	Study Population	
Aetna	110	15	95	11	99	-4
Amerigroup	110	21	89	12	98	-9
Fidelis Care	110	14	96	5	105	-9
Horizon	110	15	95	17	93	2
United	110	36	74	44	66	8
Total	550	101	449	89	461	-12

MCO: managed care organization.

Table 33 shows compliance at the service level for the individual MCOs, while **Table 34** shows compliance at the service level across all plans. The denominators displayed in **Table 33** and **Table 34** are the number of members who had the indicated service documented in their POC during the measurement period, while the numerators are the number of members whose average service delivery was above the 95% threshold. Note that a member can be represented in more than one service.

Across all MCOs, the most common MLTSS service was PCA; of the 248 members who had PCA services planned, 112 (45.2%) received, on average, 95% or more of the planned amount. Across all plans, Assisted Living Service was associated with the highest proportion of members reaching the 95% average threshold of the MLTSS services listed; of the 34 members who had Assisted Living Services planned, 26 (76.5%) received, on average, 95% or more of the planned amount.

For services with a denominator greater than or equal to 10 in **Table 34**, improvement was seen over the prior year for the Assisted Living, Home Delivered Meals, PCA and PERS Monitoring services. Rates with a denominator less than 10 are listed for reference only. Rates for services for which the denominator is less than 30 should be reviewed with caution. For rates across all plans, the compliance rate of PERS Monitoring with a denominator of more than 10 increased the most, showing an increase of 34.1 percentage points from 40.7% in the prior year to 74.8% in the current year; the performance of Medical Day Services decreased the most, showing a decrease of 32.7 percentage points from 75.3% in the prior year to 42.6% in the current year.

Table 33: Proportion of MLTSS Services at or above the 95% Average Service Delivery Threshold, by MCO

Services Evaluated	Aetna				Amerigroup				Fidelis Care				Horizon				United			
	D	N	2022 %	2021 %	D	N	2022 %	2021 %	D	N	2022 %	2021 %	D	N	2022 %	2021 %	D	N	2022 %	2021 %
Adult Family Care																				
Assisted Living Services/Programs	8	7	87.5%[a,b1]	83.3%	10	8	80.0%	87.5%[a]	8	6	75.0%[a]	50.0%[a]	3	2	66.7%[a,b8]	61.9%	5	3	60.0%[a]	66.7%[a]
Chore Services																				
Community Residential Services	2	0	0.0%[a]										6	0	0.0%[a]	0.0% [a]				
Home Delivered Meals	19	4	21.1%	62.5% [a]	36	10	27.8%[b4]	29.3%	18	6	33.3%	19.0%	47	24	51.1%[b9]	33.3%	23	11	47.8%[b11]	27.3%
Medical Day Services	34	12	35.3%[b2]	81.3%	20	8	40.0%[b5]	77.8%[a]	51	24	47.1%[b6]	76.3%	9	5	55.6%[a]	36.4%	8	3	37.5%[a]	71.4%[a]
Medication Dispensing Device Monthly Monitoring					4	2	50.0%[a]	0.0%[a]	4	0	0.0%[a]	0.0%[a]				0.0%[a]				0.0%[a]
PCA/Home Based Supportive Care	62	28	45.2%[b3]	25.0%	49	23	46.9%	28.8%	44	19	43.2%[b7]	47.2%	47	22	46.8%[b10]	20.0%	46	20	43.5%	25.0%
PERS Monitoring	51	42	82.4%[b3]	4.1%	50	30	60.0% [b4]	74.2%	52	41	78.8%	47.5%	62	46	74.2%[b9]	41.5%	27	22	81.5%[a,b12]	0.0%
Private Duty Nursing	2	0	0.0%[a]		1	0	0.0%[a]						1	1	100.0%[a]		5	0	0.0%[a]	0.0%[a]

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

[b1] Both denominator and numerator decreased this year for Assisted Living Services/Programs, the denominator decreased from 12 to 8 and the numerator decreased from 10 to 7. However, there is no statistically significant difference between the 2022 and 2021 rates.

[b2] Both denominator and numerator decreased this year for Medical Day Services, the denominator decreased from 64 to 34 and the numerator decreased from 52 to 12. The rate for 2022 is statistically significantly lower than the rate for 2021.

[b3] Both denominator and numerator increased this year: for PCA, the denominator increased from 44 to 62 and the numerator increased from 11 to 28; for Personal Emergency Response System (PERS) Monitoring, the denominator increased from 49 to 51 and the numerator increased from 2 to 42. The rates for 2022 are statistically significantly higher than the rate for 2021.
[b4] Both denominator and numerator decreased this year: for Home Delivered Meals, the denominator decreased from 41 to 36 and the numerator decreased from 12 to 10; for PERS Monitoring, the denominator decreased from 66 to 50 and the numerator decreased from 49 to 30. However, there is no statistically significant difference between the 2022 and 2021 rates.
[b5] Both denominator and numerator increased this year: for Medical Day Services, the denominator increased from 9 to 20 and the numerator increased from 7 to 8.
[b6] Both denominator and numerator decreased this year: for Medical Day Services, the denominator decreased from 59 to 51 and the numerator decreased from 45 to 24. The rate for 2022 is statistically significantly lower than the rate for 2021.
[b7] Both denominator and numerator decreased this year: for Personal Care Assistant (PCA), the denominator decreased from 53 to 44 and the numerator decreased from 25 to 19. However, there is no statistically significant difference between the 2022 and 2021 rates.
[b8] Both denominator and numerator decreased this year: for Assisted Living Services, the denominator decreased from 21 to 3 and the numerator decreased from 13 to 2.
[b9] Both denominator and numerator increased this year: for Home Delivered Meals, the denominator increased from 36 to 47 and the numerator increased from 12 to 24; for PERS Monitoring, the denominator increased from 53 to 62 and the numerator increased from 22 to 46. However, there is no statistically significant difference between the 2022 and 2021 rates.
[b10] Both denominator and numerator increased this year: for PCA, the denominator increased from 40 to 47 and the numerator increased from 8 to 22. The rates for 2022 are statistically significantly higher than the rate for 2021.
[b11] Both denominator and numerator increased this year: for Home Delivered Meals, the denominator increased from 22 to 23 and the numerator increased from 6 to 11. However, there is no statistically significant difference between the 2022 and 2021 rates.
[b12] Both denominator and numerator increased this year: for PERS Monitoring, the denominator increased from 21 to 27 and the numerator increased from 0 to 22. The rates for 2022 are statistically significantly higher than the rate for 2021.
Gray shading: zero denominator (D) for the service, so numerator (N) and rate is not applicable.
MLTSS: Managed Long-Term Services and Supports.

Table 34: Proportion of MLTSS Services At or Above the 95% Average Service Delivery Threshold, All Plans

Services Evaluated	All Plans 2022			2021			Change from 2021
	D	N	%	D	N	%	
Adult Family Care							
Assisted Living Services/Programs	34	26	76.5%	48	34	70.8%	5.7%
Chore Services							
Community Residential Services	8	0	0.0% [a]	2	0	0.0%[a]	0.0%
Home Delivered Meals	143	55	38.5%	128	39	30.5%	8.0%
Medical Day Services	122	52	42.6%	150	113	75.3%	-32.7%
Medication Dispensing Device Monthly Monitoring	8	2	25.0%[a]	6	0	0.0%[a]	25.0%
PCA/Home Based Supportive Care	248	112	45.2%	244	73	29.9%	15.3%
PERS Monitoring	242	181	74.8%	248	101	40.7%	34.1%
Private Duty Nursing	9	1	11.1%[a]	1	0	0.0%[a]	11.1%

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

Table 35 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 37.4%, an increase of 8.5 percentage points from the rate of 28.9% for the prior year. It is observed that all MCOs demonstrated better performance this year: Aetna's compliance rate increased by 3.4 percentage points to 33.7%, Amerigroup's compliance rate increased by 7.5 percentage points to 37.1%, Fidelis Care's compliance rate increased by 3.4 percentage points to 39.6%, Horizon's compliance rate increased by 12.0 percentage points to 38.9%, and United's compliance rate increased by 21.1 percentage points to 37.8%. Fidelis Care achieved the highest compliance rate, with a rate of 39.6% (**Table 35**).

As noted above, compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must score at or above 95% for each service documented in the POC for each member. Of the 449 total members in the denominator, 168 (37.4%) received, on average, 95% of the planned service amount for all services documented in the POC (**Table 35**).

Table 35: Compliance Rates

MCO	Current Year (2022)			Prior Year (2021)			Change in Rate from Prior Year
	Denominator	Numerator	Compliance Rate	Denominator	Numerator	Compliance Rate	
Aetna	95	32	33.7%	99	30	30.3%	3.4%
Amerigroup	89	33	37.1%	98	29	29.6%	7.5%
Fidelis Care	96	38	39.6%	105	38	36.2%	3.4%
Horizon	95	37	38.9%	93	25	26.9%	12.0%
United	74	28	37.8%	66	11	16.7%	21.1%
Total	449	168	37.4%	461	133	28.9%	8.5%

MCO: Managed Care Organization.

2022 MLTSS Service Delivery Project

MLTSS Service Delivery evaluates compliance of the delivery of four specific MLTSS services, in accordance with the MLTSS members' Plan of Care (POCs) for HCBS members for NJ Medicaid and FIDE SNP MCOs. The four services are : Home Delivered Meals (HDM), Medical Day Care (MDC), Personal Care Assistance (PCA, and Personal Emergency Response System (PERS). Evaluation of POC compliance with service delivery is based on type, scope, amount, frequency, and duration of service. In addition to evaluating delivery of services in accordance with the POC, the project also includes evaluation of the MCOs against the following PMs:

- PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS HCBS;
- PM #10: Plans of Care are aligned with members needs based on the results of the NJCA; and
- PM #11: Plans of Care developed using "person-centered principles."

In 2022, the MLTSS Service Delivery Project was based on the measurement period January 1, 2020–December 31, 2020. A sample of 120 cases for each of the MLTSS services and new enrollees to be evaluated for PM #8 was selected for each MCO, based on the authorization and enrollment data provided by the MCOs for the measurement period. IPRO developed an algorithm to minimize the number of unique cases required to ensure that there were 120 cases for each service type and to ensure that 120 new enrollees would be included for calculation of PM #8.

MCOs were required to provide claims data files, source code, POCs, and supplemental documentation of CM notes for validation. IPRO conducted an analysis of POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. POCs that contained no information about the MLTSS services were excluded from the evaluation of the MLTSS services, but were included for scoring PM #8, PM #10, and PM #11. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (black-out periods). After all of the files passed validation, IPRO proceeded with the primary source verification with each MCO, to ensure that their reported claims accurately reflected the claims in their transactional systems.

Evaluation Methodology

MLTSS service delivery 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. PERS services were evaluated on a monthly basis.

MLTSS Services are often provided on a weekly schedule that is customized for the member's needs. For instance, a member may require 16 units of Personal Care Assistant (PCA) service per day on weekdays, but only 8 units per day on weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis. The cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday, and any incomplete weeks were dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline. If there were any blackout periods or planned service discontinuations documented, they were removed from the timeline of expected services at the service level.

IPRO 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 percentage of service delivery for each week/month. The percentage of service delivery could never exceed 100% for any given

week/month. Where claims indicated that more than 100% of the expected service units were delivered, the percentage was capped at 100%. This 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.

The evaluation of MLTSS Service Delivery is the average of service delivery versus planned amount for all members within the review period for each service.

- PM #8: IPRO requested initial enrollment date into MLTSS for the samples selected. PM #8 requires that the member be newly enrolled in MLTSS during the review period. The MLTSS Service Delivery samples were augmented to include sufficient cases from each MCO to ensure a sample of 120 cases for each MCO for PM #8.
- PM #10 and PM #11: In addition to the POCs submitted for the MLTSS Service Delivery samples, IPRO requested copies of the NJ Choice Assessment for each member in the sample. This information was used to evaluate MCO compliance with PM #10. Compliance with PM #11 was determined based on a review of the POCs submitted for MLTSS Service Delivery.

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

Conclusions and Comparative Findings

This is the evaluation of MLTSS Service Delivery for these four services, (PCA, MDC, HDM and PERS). The final report was submitted in May 2023. The overall performance rates for PM #8, PM #10, and PM #11ranged from 71% for PM #8 to 94% for PM #11. The overall performance rates for each service of the MLTSS Service Delivery evaluation ranged from 68% for Home Delivered Meals to 89% for PERS.

As shown in **Table 36**, a total of 1,491 cases were sampled from the authorizations across all MCOs. For each MCO, an algorithm was used to minimize the number of unique cases required to ensure that there were 120 cases for each service type and PM #8. Sample sizes varied by MCO (**Table 36**).

Table 36: MLTSS Service Delivery Sample Summary

MCO:	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP	Total
Unique cases sampled	339	265	416	289	182	1,491

MCO: managed care organization.

Table 37 presents service rates by MCO and for the overall sample. The overall percentages of service delivery versus expected services ranges from 68% of Home Delivered Meals to 89% of PERS. For all MCOs, Home Delivered Meals has the lowest rate, while PERS shows the highest delivery rate for three of the five MCOs. Among the MCOs, ABHNJ has the best performance with highest rate for Medical Day Care and HNJH has the best performance with highest rate for PERS.

Table 37: Rate of Service Delivery Versus Planned Amount

MCO	Home Delivered Meals	Medical Day Care	Personal Care Assistant	Personal Emergency Response System
ABHNJ	81%	93%	82%	88%
AGNJ	79%	88%	81%	89%
HNJH	81%	83%	82%	93%
UHCCP	71%	75%	76%	89%
FC/WCHP	22%	89%	72%	86%
Statewide[1]	68%	85%	79%	89%

[1] The statewide rate is the weighted average of the managed care organization (MCO) rates.

Table 38 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), #10 (Plans of Care are aligned with member needs based on the results of the NJ Choice Assessment), and #11 (Plans of Care developed using "Person-Centered Principles"). The overall performance rates for PM #8, PM #10, and PM #11 ranged from 71% for PM #8 to 94% for PM #11 (**Table 38**).

Table 38: Results of Performance Measures

Performance Measure	MCO	Denominator	Numerator	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS[1]	ABHNJ	120	78	65%
	AGNJ	120	103	86%
	HNJH	120	98	82%
	UHCCP	120	69	58%
	FC/WCHP	120	77	64%
	Total	600	425	71%
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[2]	ABHNJ	41	38	93%
	AGNJ	85	42	49%
	HNJH	50	47	94%
	UHCCP	55	35	64%
	FC/WCHP	61	61	100%
	Total	292	223	76%
#11. Plans of Care developed using "Person-Centered Principles"[3]	ABHNJ	120	102	85%
	AGNJ	120	113	94%
	HNJH	120	120	100%
	UHCCP	120	107	89%
	FC/WCHP	120	120	100%
	Total	600	562	94%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an initial plan of care.
[2] Members are excluded from this measure if they do not have a completed New Jersey Choice Assessment (NJCA) or a completed plan of care (POC). Due to the 2019 novel coronavirus (COVID-19) pandemic, only members enrolled between January 2020 and March 2020 were considered eligible for PM #10. Administration of the NJCA was suspended from March 2020 until mid-November 2021.
[3] 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.

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

Objectives

Results from the HEDIS CAHPS 2023 5.1H Surveys for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following two survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare MCOs: Center for the Study of Services (CSS) and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and FC/WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All the members surveyed required continuous enrollment from July 1, 2022, through December 31, 2022, 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.

Technical Methods of Data Collection and Analysis

The survey drew, as potential respondents, adult enrollees over the age of 18 years, and children under the age of 18 years who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2023 using a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. All five health plans utilized the mail and telephone protocol. Additionally, ABHNJ, HNJH and UHCCP offered the option to complete the survey online. For the Child CAHPS survey, ABHNJ opted to send a third survey mailing to those who had not responded to the first two mailings.

Description of Data Obtained and Conclusion

For the adult survey, a total random sample of 8,033 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,668 ABHNJ, 1,350 AGNJ, 1,755 HNJH, 1,890 UHCCP, and 1,350 FC/WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,224 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 15.5%, which was similar to the previous year's response rate of 15.6%. Composite results of the adult NJ FamilyCare overall weighted responses for the five MCOs were: 93.9% for how well doctors communicate; 87.8% for customer service; 76.9% for getting needed care; and 78.5% for getting care quickly (**Table 40**).

For the child survey, a total random sample of 10,527 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 2,772 ABHNJ, 1,650 AGNJ, 2,475 HNJH, 1,980 UHCCP, and 1,650 FC/WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,866 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 18.0%, which was similar to the previous year's response rate of 18.2%. The composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 92.2% for how well doctors communicate; 87.6% for customer service; 79.1% for getting needed care; and 78.9% for getting care quickly (**Table 41**).

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 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 465 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 21.9%, which was a decrease from last year's response rate of 22.8%. Composite results of the CHIP NJ FamilyCare

overall statewide responses were: 94.8% for how well doctors communicate; 87.4% for customer service; 80.5% for getting needed care; and 77.8% for getting care quickly (data now shown).

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 39**.

Table 39: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2022 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2022Quality Compass National Percentiles
Orange	Less than 25th percentile
Yellow	Greater than or equal to 25th and less than 50th percentile
Green	Greater than or equal to 50th and less than 75th percentile
Blue	Greater than or equal to 75th and less than 90th percentile
Purple	Great than or equal to the 90th percentile

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

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all MCOs, IPRO compared the NJ FamilyCare overall statewide weighted averages for adults and children (**Table 40** and **Table 41**, respectively) to the national Medicaid benchmarks presented in the MY 2022 Quality Compass. Measures performing at or above the 75th percentile and below the 90th percentile, and greater than or equal to the 90th percentile were considered strengths; measures performing at the 50th percentile and below the 75th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Table 40: CAHPS MY 2022 Performance – Medicaid Adult Survey

Adult Survey – CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP	Statewide Weighted Average
Getting Needed Care	79.3%	81.7%	76.2%	74.3%	80.7%	76.9%
Getting Care Quickly	75.3%	81.8%	78.5%	76.6%	81.0%	78.5%
How Well Doctors Communicate	94.9%	93.9%	94.9%	91.1%	91.1%	93.9%
Customer Service	89.1%	91.9%	88.8%	82.2%	85.5%	87.8%
Rating of All Health Care[1]	71.7%	72.6%	80.1%	71.3%	72.4%	76.8%
Rating of Personal Doctor[1]	85.3%	82.0%	84.1%	84.5%	78.5%	83.6%
Rating of Specialist Seen Most Often[1]	81.0%	84.8%	83.5%	73.2%	71.8%	81.1%
Rating of Health Plan[1]	74.4%	78.1%	81.3%	77.3%	75.7%	79.4%

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

Color key for how rate compares to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measurement year (MY 2022) Quality Compass national percentiles: orange shading – less than 25th percentile; yellow shading – greater than or equal to 25th and less than 50th percentile; green shading is greater than or equal to 50th and less than 75th percentile; blue shading – greater than or equal to 75th and less than 90th percentile; purple shading – greater than or equal to the 90th percentile.

CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Table 41: CAHPS MY 2022 Performance – Medicaid Child Survey

Child Survey – CAHPS Measure	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP	Statewide Weighted Average
Getting Needed Care	81.4%	83.1%	76.2%	84.4%	81.9%	79.1%
Getting Care Quickly	81.7%	83.3%	76.9%	81.6%	76.2%	78.9%
How Well Doctors Communicate	93.5%	94.4%	91.3%	93.8%	91.1%	92.2%
Customer Service	88.5%	91.0%	84.9%	91.3%	86.6%	87.6%
Rating of All Health Care	84.1%	88.5%	82.2%	83.6%	81.2%	83.4%
Rating of Personal Doctor[1]	88.1%	90.3%	83.4%	93.5%	90.1%	86.7%
Rating of Specialist Seen Most Often[1]	81.2%	87.0%	83.7%	85.5%	81.5%	84.3%
Rating of Health Plan[1]	78.7%	86.4%	84.6%	89.3%	86.0%	85.5%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.
Color key for how rate compares to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measurement year (MY 2022) Quality Compass national percentiles: orange shading – less than 25th percentile; yellow shading – greater than or equal to 25th and less than 50th percentile; green shading is greater than or equal to 50th and less than 75th percentile; blue shading – greater than or equal to 75th and less than 90th percentile; purple shading – greater than or equal to the 90th percentile.
CAHPS: Consumer Assessment of Healthcare Providers and Systems.

Weighted statewide average rates ranked at or above the NCQA national 50th percentile for four of the eight adult measures (**Table 40**). Opportunities for improvement are evident for the four adult measures (Getting Needed Care, Getting Care Quickly, Customer Service, and Rating of Specialist Seen Most Often). Opportunities for improvement are evident for all eight child measures (**Table 41**).

For the adult survey measures, HNJH had one measure above the national 90th percentile, two measures between the 75th and 90th percentiles, and two measures between 50th and 75th percentiles. AGNJ had two measures between the 75th and 90th percentiles and four measures between the 50th and 75th percentiles. ABHNJ had two measures between the 75th and 90th percentiles. UHCCP with one measure between the 50th and 75th percentiles. All eight measures were below the 50th percentile for FC/WCHP (**Table 40**).

For the child survey measures, ABHNJ and FC/WCHP had one measure above the 50th national percentile. AGNJ had two measures between the 75th and 90th percentiles and four measures between the 50th and 75th percentiles. UHCCP had one measure above the national 90th percentile, one measure between the 75th and 90th percentiles, and three measures between the 50th and 75th percentiles. All eight measures were below the 50th percentile for HNJH (**Table 41**).

VII. Care Management Audits

2023 Core Medicaid Care Management Audits

The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM program. DMAHS established CM requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, *NJ Care Management Workbook*, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

One metric (Identification) was only evaluated for the General population. This metric is not relevant for the DDD and DCP&P populations, because CM is required for those populations. Four metrics (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for all three populations (GP, DDD and DCP&P) within the five participating MCOs (ABHNJ, AGNJ, FC/WCHP, HNJH, and UHCCP), for a total of 65 scores.

Assessment Methodology

The audit addressed MCO Contract requirements for CM services including NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the *NJ Care Management Workbook*. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Summary of Core Medicaid Care Management Audit Performance

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 42**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population. Compliance threshold in an audit category is 85% or above.

Table 42: Core Medicaid Care Management Summary of Performance

Determination by Category[1]	MCO				
	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP
	MY 2022	MY 2022	MY 2022	MY 2022	MY 2022
GP	n = 100	n = 100	n = 100	n = 100	n = 100
Identification[2]	64%	72%	75%	57%	78%
Outreach	91%	81%	82%	100%	86%
Preventive Services	73%	46%	61%	73%	67%
Continuity of Care	89%	59%	86%	87%	90%
Coordination of Services	96%	83%	98%	96%	95%
DDD	n = 15	n = 15	n = 84	n = 24	n = 22
Outreach	100%	100%	96%	100%	71%
Preventive Services	56%	62%	81%	71%	46%
Continuity of Care	98%	95%	92%	95%	87%
Coordination of Services	100%	100%	100%	100%	77%
DCP&P	n = 17	n = 26	n = 97	n = 41	n = 7
Outreach	100%	97%	100%	100%	75%
Preventive Services	66%	81%	84%	83%	58%
Continuity of Care	89%	95%	95%	96%	94%
Coordination of Services	100%	100%	100%	98%	92%

[1] The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).
[2] The Identification category is not evaluated for the DDD and DCP&P populations.

ABHNJ's 2023 audit results ranged from 56% to 100% across all populations for the five audit categories.

AGNJ's 2023 audit results ranged from 46% to 100% across all populations for the five audit categories.

HNJH's 2023 audit results ranged from 61% to 100% across all populations for the five audit categories.

UHCCP's 2023 audit results ranged from 57% to 100% across all populations for the five audit categories.

FC/WCHP's 2023 audit results ranged from 46% to 95% across all populations for the five audit categories.

Core Medicaid Care Management and Continuity of Care Annual Assessment

Assessment Methodology

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

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

The 2023 CM assessment covered the period from January 1, 2022, to December 31, 2022. Interviews with key MCO staff were held remotely in May 2023.

There were 30 elements in this review based on contractual provisions, which are subject to review annually. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17 and CM19 was based on results from the 2023 Core Medicaid file review. Overall compliance scores for the five MCOs ranged from 70% to 80% (**Table 43**). Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations: namely the Enrollees under the General Population (GP), the Division of Developmental Disabilities (DDD) and the Division of Child Protection and Permanency (DCP&P). **Table 43** presents an overview of the results by MCO.

Table 43: Summary of Findings for 2023 Core Medicaid Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	30	21	9	70%
AGNJ	30	22	8	73%
HNJH	30	23	7	77%
UHCCP	30	24	6	80%
FC/WCHP	30	22	8	73%

MCO: managed care organization.

Table 44 presents the summary of findings for the Core Medicaid Care Management and Continuity of Care elements reviewed in 2023. Complete findings and IPRO's recommendations for each MCO can be located in **Appendices B–F.**

Table 44: Summary of Findings for Core Medicaid Care Management and Continuity of Care

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	FC/WCHP Met
CM1	X	X	X	X	X
CM2	-	-	X	-	X
CM3	-	-	-	-	-
CM4	X	X	X	X	X
CM5	X	-	X	X	X
CM6	-	X	-	-	-
CM7	-	-	-	-	-
CM8	-	-	-	-	-
CM9	X	X	X	X	X
CM10	X	X	X	X	X
CM11	-	-	-	X	X
CM12	X	X	X	X	X
CM13	X	X	X	X	X
CM14	-	-	-	-	-

Element	ABHNJ Met	AGNJ Met	HNJH Met	UHCCP Met	FC/WCHP Met
CM15	-	-	-	X	-
CM16	X	X	X	X	X
CM17	-	X	X	X	-
CM18a	X	X	X	X	X
CM18c	X	X	X	X	X
CM18d	X	X	X	X	X
CM19	X	X	X	X	-
CM20	X	X	X	X	X
CM21	X	X	X	X	X
CM22	X	X	X	X	X
CM23	X	X	X	X	X
CM24	X	X	X	X	X
CM25	X	X	X	X	X
CM26	X	X	X	X	X
CM27	X	X	X	X	X
CM37[1]	X	X	X	X	X
Total elements = 30	21	22	23	24	22
Compliance percentage	70%	73%	77%	80%	73%

[1] This documentation element is reviewed annually as all elements are subject to review.
X indicates Met, - indicates Not Met or Not Reviewed.

None of the MCOs met the compliance threshold of 85% or above (**Table 44**). All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in **Section XI** and also in **Appendices B–F**.

2023 MLTSS Nursing Facility Care Management Audits

The purpose of the MLTSS NF/SCNF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special-needs members who met MLTSS eligibility requirements as specified in Article 9 are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in an NF/SCNF for at least 6 consecutive months within the review period. Typically, the review period for the annual NF audit is from July 1st through June 30th. Due to the COVID-19 pandemic, the prior review period was from January 1, 2021, through August 14, 2021, during which time Face-to-Face visits were suspended and access to NFs was restricted. The review period for this audit was August 15, 2021, through August 31, 2022, during which DMAHS issued the *MCO Care Management Guidance*. Effective November 16, 2021, MCO care managers were to expand Face-to-Face visits to all MLTSS members and resume completion of the NJCA. COVID-19 flexibilities were in place related to specific CM activities, allowing telephonic visits for members who refused an in-person visit, and for NFs with visitation protocols restricting care manager access. In addition to the CM audit, MLTSS PMs #8, #9, #9a, #11, and #16 were calculated.

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

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the MCO Contracts in Article 9 from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July

2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

Pre-Audit Planning Activities

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJCA System, POC, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022, to coincide with the State's extension deadline for return to field activities, disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added to the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members counted in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a POC for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to an NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF populations. Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and an NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes. "Population Selection Capitation" and "Plan" codes were used to identify MLTSS NF/SCNF enrollment. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected up to 110 cases for each MCO, inclusive of an oversample of 10 cases to replace any excluded files, as necessary.

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 45**.

Table 45: MLTSS NF/SCNF Population Subgroups

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in an NF/SCNF at least 6 consecutive months from August 15, 2021, to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in an NF/SCNF for at least 6 consecutive months from August 15, 2021, to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021, to August 31, 2022, and transitioned to an NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021, to August 31, 2022, transitioned to an NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

MLTSS: Managed Long-Term Services and Supports; NF: nursing facility; SCNF: special care nursing facility; MCO: managed care organization; HCBS: Home and Community Based Services.

The 2023 MLTSS NF/SCNF Audit Results are presented in **Table 46**.

2023 MLTSS NF/SCNF Audit Results

Table 46: 2023 MLTSS NF/SCNF Audit Results

Category	August 15, 2021, to August 31, 2022															NJ Weighted Average[3]
	ABHNJ			AGNJ			FC/WCHP			HNJH			UHCCP			
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	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.	79	100	79.0%	97	100	97.0%	90	100	90.0%	98	100	98.0%	65	100	65.0%	85.8%
Documented review of the Facility Plan of Care by the Care Manager.	73	79	92.4%	97	97	100.0%	88	90	97.8%	98	98	100.0%	65	65	100.0%	98.1%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	73	79	92.4%	97	97	100.0%	88	90	97.8%	98	98	100.0%	61	65	93.8%	97.2%
MLTSS Initial Plan of Care and Ongoing Plans of Care																
The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS).	0	4	0.0%	2	5	40.0%	2	4	50.0%	10	10	100.0%	1	12	8.3%	42.9%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	76	100	76.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	96	100	96.0%	94.2%
Care Manager arranged Plan of Care services using both formal and informal supports.	76	100	76.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	96	100	96.0%	94.2%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	76	100	76.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	96	100	96.0%	94.2%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2-	76	100	76.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	96	100	96.0%	94.2%

Category	August 15, 2021, to August 31, 2022															
	ABHNJ			AGNJ			FC/WCHP			HNJH			UHCCP			NJ Weighted Average[3]
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).																
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	76	100	76.0%	97	100	97.0%	99	100	99.0%	100	100	100.0%	96	100	96.0%	93.6%
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	1	100.0%	3	4	75.0%	1	2	50.0%	11	13	84.6%	0	0	N/A[1]	N/A[1]
Transition Planning																
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	6	100	6.0%	21	100	21.0%	4	100	4.0%	6	100	6.0%	4	100	4.0%	8.2%
Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	45	100	45.0%	7	100	7.0%	42	100	42.0%	5	100	5.0%	1	100	1.0%	20.0%
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	81	100	81.0%	100	100	100.0%	100	100	100.0%	100	100	100.0%	99	100	99.0%	96.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-	23	100	23.0%	66	100	66.0%	66	100	66.0%	89	100	89.0%	54	100	54.0%	59.6%

Category	August 15, 2021, to August 31, 2022															
	ABHNJ			AGNJ			FC/WCHP			HNJH			UHCCP			NJ Weighted Average[3]
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).																
Members requiring coordination of care had coordination of care by the Care Manager.	99	100	99.0%	100	100	100.0%	100	100	100.0%	97	100	97.0%	99	100	99.0%	99.0%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission.	72	100	72.0%	99	100	99.0%	98	100	98.0%	98	100	98.0%	72	100	72.0%	87.8%
Reassessment of the Plan of Care and Critical Incident Reporting																
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	62	100	62.0%	100	100	100.0%	96	100	96.0%	97	100	97.0%	79	100	79.0%	86.8%
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.	75	100	75.0%	89	100	89.0%	89	100	89.0%	100	100	100.0%	21	100	21.0%	74.8%
Care Manager reviewed the Member's rights and responsibilities.	76	100	76.0%	100	100	100.0%	100	100	100.0%	94	100	94.0%	53	100	53.0%	84.6%
Care Manager educated the Member on how to file a grievance and/or an appeal.	76	100	76.0%	100	100	100.0%	100	100	100.0%	94	100	94.0%	55	100	55.0%	85.0%
Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation.	75	100	75.0%	100	100	100.0%	100	100	100.0%	96	100	96.0%	54	100	54.0%	85.0%
Transitions to HCBS[2]																
NJCA was completed to assess the Member's needs prior to discharge from an NF/SCNF.										1	1	100.0%				N/A
Cost effectiveness evaluation was completed for the Member prior to discharge from an NF/SCNF.										1	1	100.0%				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.										1	1	100.0%				N/A
Participation in an interdisciplinary team (IDT) meeting										1	1	100.0%				N/A

Category	August 15, 2021, to August 31, 2022															
	ABHNJ			AGNJ			FC/WCHP			HNJH			UHCCP			NJ Weighted Average[3]
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	Rate
related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.																
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer.										1	1	100.0%				N/A
Care Manager conducted a Face-to-Face visit within 10 business days following a NF/SCNF discharge to the community.										1	1	100.0%				N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.										1	1	100.0%				N/A
Transitions to NF/SCNF[2]																
Member had a person-centered transition plan on file.										1	1	100.0%				N/A
Care Manager completed a risk management agreement for the Member when indicated.										0	0	N/A				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.										1	1	100.0%				N/A

[1] UHCCP had no Members who met criteria for this element, therefore the New Jersey (NJ) weighted average could not be determined.
[2] There is no data to report for ABHNJ, AGNJ, FC/WCHP, and UHCCP, as no Members were identified in Groups 2, 3, and 4 (transitions between Managed Long-Term Services and Supports [MLTSS] settings during the review period).
[3] HNJH had one Member identified in the same denominator for Groups 2 and 3. The NJ weighted average could not be determined.
N/A: not applicable; NF: nursing facility; SCNF: special care nursing facility; CM: care management; NJCA: Ner Jersey Choice Assessment.

As seen in **Table 46**, for the review period August 15, 2021, through August 31, 2022, all of the five MCOs scored at or above 86% for "MLTSS Plans of Care on file" and four of the five MCOs scored at or above 86% for "Members present at each telephonic visit"; none of the five MCOs scored at or above 86%, for "Members identified for transfer to HCBS"; four of the five MCOs scored at or above 86%, for Member and/or representative participated in the development of goals" (**Table 46**).

Twenty-one (21) individual elements were evaluated across all five MCOs (**Table 46**). Three of the five MCOs scored at or above 86% for 15 or more elements: HHNJ scored at or above 86% for 18 elements; and AGNJ and FC/WCHP scored at or above 86% for 16 elements. UHCCP scored at or above 86% for only nine (9) elements; ABHNJ scored at or above 86% for only four (4) elements. Individual recommendations were provided to the MCOs with their final report (**Table 46**).

Results of MLTSS NF Performance Measures

Beginning in 2021, the expansion of the MLTSS NF/SCNF audit included the evaluation of the MLTSS PMs for the NF/SCNF population. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings by MCO in **Table 47** present the results on the following MLTSS PMs: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #9 (Member's Plan of Care is reviewed annually within 30 days of Member's anniversary and as necessary), #9a (Member's Plan of Care is amended based on change of Member condition), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents).

Table 47: Results of MLTSS NF/SCNF Performance Measures –August 15, 2021, to August 31, 2022

Performance Measure	ABHNJ	AGNJ	FC/WCHP	HNJH	UHCCP	NJ Weighted Average
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	0.0%	40.0%	50.0%	100.0%	8.3%	42.8%
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	76.0%	100.0%	100.0%	94.0%	53.0%	84.6%
#9a. Member's Plan of Care is amended based on change of member condition[3]	100.0%	75.0%	50.0%	84.6%	N/A[4]	N/A[4]
#11. Plans of Care developed using "person-centered principles" [5]	76.0%	100.0%	99.0%	100.0%	96.0%	94.2%
#16. Member training on identifying/reporting critical incidents	75.0%	100.0%	100.0%	96.0%	54.0%	85.0%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an initial plan of care.
[2] 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.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] UHCCP had no Members that met the criteria to evaluate PM #9a, therefore the New Jersey (NJ) weighted average is unable to be determined.
[5] 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.
N/A: not applicable; MLTSS: Managed Long-Term Services and Supports; NF: nursing facility; SCNF: special care nursing facility.

Of the five (5) PMs calculated for the MCOs, only three had denominators large enough to comment on performance (**Table 47**). The three PMs with sufficient denominator sizes across all MCOs are PM #9 POC Reviewed Annually within 30 days of Anniversary and as Necessary, PM # 11 POC Developed Using "Person Centered Principles," and PM #16 Member Training on Identifying/Reporting Critical Incidents. Four MCOs scored at or above 86% for PM #11 (AGNJ, Fidelis Care, HNJH, and UHCCP). Three MCOs scored at or above 86% for PM #9 and PM #16 (AGNJ, Fidelis Care, and HNJH). HNJH scored at or above 86% for PM #8, and ABHNJ scored at or above 86% for PM #9a. PM #9a could not be evaluated for UHCCP due to the lack of Members who met criteria for experiencing a significant change in condition during the review period, requiring an amended Plan of Care. However, the denominator values for these Performance Measures are not significant as they are below 30 across all five MCOs (**Table 47**).

IPRO provided each MCO with a comprehensive report listing strengths and opportunities for improvement at the element level. IPRO provided the MCOs with recommendations for each opportunity for improvement. These recommendations can be found in **Appendices B–F**.

ABHNJ's MLTSS NF/SCNF Audit Results

Overall, ABHNJ scored 86% or above in the following review elements (Table 46):

- Documented Review of the Facility Plan of Care (92.4%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (92.4%)
- 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 (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (99.0%)

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 46):

- Member's CM record contained copies of any Facility Plans of Care on file during the review period (79.0%)
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS) (0.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (76.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (76.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (76.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (76.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (76.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (6.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (Participation in an IDT meeting may be substituted for one Member visit) (45.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (81.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Telephonic or 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) (23.0%)
- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (72.0%)

- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (62.0%)
- 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 (75.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (76.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (76.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (75.0%)

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (Table 47):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (0.0%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary (76.0%)
- #11. Plans of Care developed using "person-centered principles" (76.0%)
- #16. Member training on identifying/reporting critical incidents (75.0%)

AGNJ's MLTSS NF/SCNF Audit Results

Overall, AGNJ scored 86% or above in the following review elements (Table 46):

- Member's CM record contained copies of any Facility Plans of Care on file during the review period (97.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (100.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (100.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (97.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (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 (99.0%)

- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (100.0%)
- 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 (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (100.0%)

AGNJ's Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 46):

- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty--five (45) calendar days of enrollment notification into the MLTSS program (40.0%)
- 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 (75.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (21.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (7.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (66.0%)

Opportunities for improvement for PMs that scored below 86% exist for the following (Table 47):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (40.0%)
- #9a. Member's Plan of Care is amended based on change of Member condition (75.0%)

FC/WCHP's MLTSS NF/SCNF Audit Results

Overall, FC/WCHP scored 86% or above in the following review elements (Table 46):

- Member's CM record contained copies of any Facility Plans of Care on file during the review period (90.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (97.8%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (97.8%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (99.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (99.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (99.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during

each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (99.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (99.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (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 (98.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (96.0%)
- 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 (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (100.0%)

FC/WCHP's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 46):
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (50.0%)
- 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 (50.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (4.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (42.0%)
- Onsite/Telephonic 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) (66.0%)

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (Table 47):
- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (50.0%)
- #9a. Member's Plan of Care is amended based on change of Member condition (50.0%)

HNJH's MLTSS NF/SCNF Audit Results

Overall, HNJH scored 86% or above in the following review elements (Table 46):
- Member's CM record contained copies of any Facility Plans of Care on file during the review period (98.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (100.0%)

- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS) (100.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (100.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (100.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (89.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (97.0%)
- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (98.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (97.0%)
- 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 (100.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (94.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (94.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (96.0%)

HNJH's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 46):

- 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 (84.6%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (6.0%)

- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (5.0%)

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (Table 47):

- #9a. Member's Plan of Care is amended based on change of Member condition (84.6%)

UHCCP's MLTSS NF/SCNF Audit Results

Overall, UHCCP scored 86% or above in the following review elements (Table 46):

- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (93.8%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (96.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (96.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (96.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (96.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (96.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (99.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (99.0%)

UHCCP's opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (Table 46):

- Member's CM record contained copies of any Facility Plans of Care on file during the review period (65.0%)
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (8.3%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (4.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (1.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (54.0%)

- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (72.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (79.0%)
- 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 (21.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (53.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (55.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (54.0%)

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (Table 47):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (8.3%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary (53%)
- #16. Member training on identifying/reporting critical incidents (54.0%)

2023 MLTSS HCBS Care Management Audits

The purpose of the MLTSS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special-needs members who met MLTSS eligibility requirements as specified in Article 9 are consistent with professionally recognized standards of care. Effective November 16, 2021, following state guidance, MCOs expanded Face-to-Face visits to all MLTSS members and resumption of the NJCA. The COVID-19 flexibilities were in place related to specific CM activities to allow care managers to conduct telephonic monitoring if the member refused an in-person visit, including the NJCA Face-to-Face visit, with evidence of documented refusals in the member file. In addition, the NJ DHS, Division of Aging Services, Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or CARS, for at least 6 consecutive months within the review period July 1, 2022 to June 30, 2023 (**Table 48**).

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Table 48: Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.

Subpopulations	Criteria
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS: Managed Long-Term Services and Supports; HCBS: Home and Community Based Services; MCO: managed care organization.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS Members in subgroup E as a base sample. A 10% oversample across all subgroups was drawn for substitution of exclusions. All MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate PMs. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS PM #8 (Plans of Care established within 45 days of MLTSS enrollment).

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment and applying the sampling methodology described in **(Table 48).**

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

MLTSS HCBS Results by Category

Table 49 presents a summary based on file review of the MCOs' performance. Based on the audit tool, there were six categories of review elements (Assessment, Member Outreach, Telephonic Monitoring or Face-to-Face Visits, Initial Plans of Care/Ongoing Plans of Care (including Back-up Plans), Ongoing CM and Gaps in Care/Critical Incidents). The results of individual review elements under each topic were calculated and rolled-up to produce a compliance score for each category.

Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 49**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 49: 2023 MLTSS HCBS Results by Category

Determination by Category 7/1/2022 – 6/30/2023	AETNA				AMERIGROUP				FIDELIS CARE				HORIZON				UNITEDHEALTHCARE				NJ Weighted Average[2]
	Group[1]				Group[1]				Group[1]				Group[1]				Group[1]				
	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	C	D	E	Total	
Assessment	100.0%	100.0%	96.0%	98.4%	100.0%	98.6%	100.0%	99.2%	100.0%	91.2%	92.0%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	84.0%	96.0%	89.4%	95.6%
Member Outreach[3]	95.0%	100.0%		98.6%	83.3%	73.9%		74.7%	77.8%	92.1%		90.3%	100.0%	85.4%		92.0%	42.9%	33.8%		34.7%	78.2%
Telephonic Monitoring or Face-to-Face Visits	72.3%	78.1%	66.7%	74.3%	100.0%	98.6%	98.9%	98.7%	97.1%	99.3%	97.8%	98.7%	97.5%	98.3%	99.0%	98.2%	75.8%	79.0%	87.5%	80.7%	90.2%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[4]	95.7%	97.1%	91.1%	95.3%	98.9%	96.8%	98.5%	97.3%	96.1%	97.3%	95.2%	96.7%	94.2%	96.2%	95.9%	95.5%	80.9%	78.8%	84.8%	80.5%	93.3%
Ongoing Care Management	80.0%	90.0%	73.8%	84.9%	85.7%	76.2%	41.9%	70.3%	100.0%	92.8%	85.3%	92.1%	78.6%	85.4%	87.0%	83.4%	73.7%	54.0%	39.4%	53.5%	76.9%
Gaps in Care/Critical Incidents	100.0%	100.0%	85.1%	96.2%	100.0%	98.6%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	98.3%	98.7%	100.0%	98.9%	76.9%	87.0%	83.3%	85.4%	95.9%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period.
[2]The weighted average is the sum of all compliant charts (numerator) divided by the sum of all charts (denominator) and include all three subpopulations.
[3]Initial Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS.
[4]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.

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

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

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

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

Strengths and Opportunities for Improvement

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

ABHNJ

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

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

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

- Face-to-Face Visits or Telephonic Monitoring Visits (Groups C, D, E and Combined)
- Ongoing Care Management (Groups C, E and Combined)
- Gaps in Care/Critical Incidents (Group E)

AGNJ

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

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

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

- Member Outreach (Groups C, D and Combined)

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

FC/WCHP

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

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

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

- Ongoing Care Management (Group E)
- Member Outreach (Group C)

HNJH

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

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

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

- Member Outreach (Group D)
- Ongoing Care Management (Groups C, D, and Combined)

UHCCP

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

- Assessment (Groups C, E and Combined)
- Gaps in Care/Critical Incidents (Group D)
- Face-to-Face Visits or Telephonic Monitoring (Group E)

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

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

2023 MLTSS HCBS Performance Measures Findings

In review of this year's NJ weighted average scores that include all three (3) MLTSS subpopulations (July 2022 – June 2023), among all 5 MCOs, the results ranged from 73.9% to 99.8% across all seven (7) MLTSS Performance Measures **(Table 50)**.

Table 50: Performance Measures Results: Review Period July 1, 2022 to June 30, 2023

Performance Measure	Group[1]	AETNA	AMERIGROUP	FIDELIS CARE	HORIZON	UNITEDHEALTHCARE	NJ Weighted Average[6]
#8. Plans of Care established within 45 days of MLTSS enrollment.	C	85.0%	100.0%	88.9%	82.4%	14.3%	78.9%
	D	90.6%	81.2%	96.8%	90.2%	9.2%	71.5%
	E[4]						
	Ancillary C	83.3%	100.0%	100.0%	83.3%	0.0%	84.2%
	Ancillary D	94.4%	75.0%	90.5%	100.0%	26.1%	75.0%
	TOTAL	89.7%	81.6%	94.8%	88.9%	13.5%	73.9%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	C[5]						
	D[5]						
	E	92.0%	100.0%	92.0%	100.0%	91.7%	95.2%
	TOTAL	92.0%	100.0%	92.0%	100.0%	91.7%	95.2%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	C	66.7%	100.0%	N/A	N/A	100.0%	80.0%
	D	100.0%	100.0%	100.0%	N/A	25.0%	86.4%
	E	100.0%	100.0%	100.0%	100.0%	N/A	100.0%
	TOTAL	83.3%	100.0%	100.0%	100.0%	40.0%	88.9%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	C	100.0%	100.0%	100.0%	97.1%	100.0%	98.7%
	D	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	TOTAL	100.0%	100.0%	100.0%	99.0%	100.0%	99.8%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	C	95.0%	100.0%	100.0%	100.0%	100.0%	98.7%
	D	98.1%	100.0%	100.0%	100.0%	58.7%	90.6%
	E	80.0%	100.0%	100.0%	100.0%	62.5%	88.7%
	TOTAL	92.9%	100.0%	100.0%	100.0%	62.8%	91.4%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	C	100.0%	100.0%	100.0%	100.0%	50.0%	94.1%
	D	98.1%	98.5%	100.0%	100.0%	68.8%	92.2%
	E	85.7%	87.5%	100.0%	100.0%	65.2%	87.9%
	TOTAL	95.1%	95.8%	100.0%	100.0%	66.7%	91.3%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	C	100.0%	100.0%	100.0%	100.0%	71.4%	97.4%
	D	100.0%	98.6%	100.0%	100.0%	80.0%	95.2%
	E	84.0%	100.0%	100.0%	100.0%	76.0%	92.0%
	TOTAL	95.9%	99.0%	100.0%	100.0%	78.4%	94.7%

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

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

[3] Members residing in a community alternative residential setting (CARS) are excluded from this measure.

[4] Group E Members are excluded from this measure as they are not new to MLTSS.

[5] Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.

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

The following MCOs scored **86% or above** at the total level, for all applicable MLTSS subpopulations for the following Performance Measures:

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

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

- **PM #8**. Plans of Care established within 45 days of MLTSS enrollment: Amerigroup and United.
- **PM #9a**. Plan of Care for MLTSS Members amended based on change in Member condition: Aetna and United.
- **PM #11**. Plans of Care for MLTSS Members are developed using "Person-Centered Principles": United.
- **PM #12**. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan: United.
- **PM #16**. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents: United.

Return to Field MLTSS HCBS Focus Study

In 2022, at the request of DMAHS, in conjunction with the 2022 MLTSS HCBS audit, IPRO developed a focus study on return to field for the MLTSS HCBS population to evaluate the MCO's compliance with the DMAHS *Return to Field Guidance*, provided the MCOs on August 11, 2021.The guidance outlined the phase-in requirements for the MCO's to conduct CM visits for all members enrolled in MLTSS prior to August 15, 2021, and continuously enrolled in MLTSS through June 30, 2022, as well as those enrolled in populations where Face-to-Face visits are applicable.

Due to the COVID-19 pandemic, Face-to-Face visits were suspended for HCBS Members in March 2020. On August 15, 2021, MCOs were mandated to resume certain in-person CM activities. This focus study evaluated MCO compliance with the "MCO CM Visit Guidance for Phase 1: Face-to-Face Visits for MLTSS High-Risk Members" for the time period August 15, 202, to November 15, 2021.

Sampling

The sampling methodology for Group E is described in **Table 51**.

Table 51: Sampling Methodology for Group E

Group	Description
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 8/15/2021 and continuously enrolled in MLTSS through 6/30/2022	• The Member must have been initially enrolled in MLTSS HCBS prior to 8/15/2021. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2022 in the *same* MCO with no gaps in enrollment.

For Group E (**Table 51**), an initial random sample of 200 cases was drawn. This sample was matched against the high-risk cases identified by the MCO in its *Resumption of Face-to-Face Visits* report, submitted to the State in October 2021. A sample of 50 high-risk cases with an oversample of 4 cases was drawn for Group E. The 50 case files reviewed in the 2022 MLTSS HCBS CM audit were selected for this study.

Methodology

IPRO requested that the MCOs complete a cover sheet for all Group E cases. This cover sheet included gathered information on the MCO's outreach to schedule a Face-to-Face visit, the date of Member Outreach, the Result (Member agreed, refused, or other), and the Face-to-Face visit date if one occurred. Documentation substantiating the information in the cover sheet was required. IPRO abstracted data from the *2022 MLTSS HCBS CM Audit Group E Cover Sheet* from the Member files. This information was compared with the documentation in the Member file to determine MCO compliance with Member Outreach for high risk Members and Face-to-Face visits between August 15, 2021, and November 15, 2021.

Return to Field Compliance Evaluation

Four (4) elements were reviewed to determine compliance: member Face-to-Face visit occurred during review period (8/15/2021 to 6/30/2022), timely Face-to-Face visit (8/15/2021 to 11/15/2021), Timely Member Outreach to schedule Face-to-Face visit (8/15/2021 to 11/15/2021), and member refused Face-to-Face visit (8/15/2021 to 11/15/2021). **Table 52** shows the results by MCO for each review element.

Table 52: Return to Field Elements for Review Period August 15, 2021, to November 15, 2021

Compliance Elements	ABHNJ			AGNJ			HNJH			UHCCP			FC/WCHP			Average[1]
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	
Member Face-to-Face visit occurred during review period (8/15/2021 to 6/30/2022)	48	50	96.0%	49	50	98.0%	48	50	96.0%	33	50	66.0%	41	50	82.0%	87.6%
Timely Face-to-Face visit: Face-to-Face visit occurred between (8/15/2021 to 11/15/2021)	40	48	83.3%	29	49	59.2%	42	48	87.5%	15	32[2]	46.9%	18	40[3]	45.0%	64.4%
Timely Member Outreach to schedule Face-to-Face visit: For	8	8	100.0%	19	20	95.0%	6	6	100.0%	17	17	100.0%	22	22	100.0%	99.0%

Members where Face-to-Face did not occur between (8/15/21 to 11/15/21), a Member Outreach to schedule a Face-to-Face did occur																
Member refused Face-to-Face visit: For Members where a Face-to-Face did not occur between (8/15/2021 and 11/15/2021), Member refusal was documented in case file	7	8	87.5%	13	19	68.4%	3	6	50.0%	11	17	64.7%	19	22	86.4%	71.4%

[1] The average is the sum of the rates of all managed care organizations (MCOs) combined divided by the number of MCOs.
[2] Denominator excludes one member that was an inpatient hospitalization during compliance period.
[3] Denominator excludes one member that was unable to reach during compliance period.
N: numerator; D: denominator.

Results

Across all the MCOs for Member Face-to-Face visit occurred during review period (8/15/2021 to 6/30/2022), the MCO compliance rate ranged from 66.0% to 98.0% with an average of 87.6%; for Timely Face-to-Face visit: Face-to-Face visit occurred between (8/15/2021 to 11/15/2021), the MCO compliance rate ranged from 45.0% to 87.5% with an average of 64.4%; for Timely Member Outreach to schedule Face-to-Face visit: for members where Face-to-Face visit did not occur between (8/15/2021 to 11/15/2021), a Member Outreach to schedule a Face-to-Face visit did occur, the MCO compliance rate ranged from 95.0% to 100.0% with an average of 99.0%; for member refused Face-to-Face visit (8/15/2021 to 11/15/2021), the MCO compliance rate ranged from 50.0% to 87.5% with an average of 71.4%.

2023 MLTSS Care Management and Continuity of Care Annual Assessment

The purpose of the MLTSS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure, that services were provided to special-needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of a pre-offsite review of documentation provided by the five MCOs, as evidence of compliance of the standards under review; interviews with key MCO staff (held remotely in November 2023), and a post-audit evaluation of additional documentation provided by the MCOs were also reviewed.

To assist in submission of the appropriate documentation, IPRO developed the *NJ Annual Assessment of MCO Operations Document Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their CM documentation differed between MLTSS and FIDE SNP/MLTSS.

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

The MLTSS Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS CM programs for enrollees who may benefit from these services in accordance with State requirements. The rating scale for *Met* and *Not Met* elements is presented in **Table 53**.

Table 53: Rating Scale for the MCO MLTSS Annual Assessment Review of Care Management

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

There are 10 contractual provisions in the 2023 MLTSS CM category. **Table 54** presents the total compliance scores of 100% for all five MCOs.

Table 54: Compliance Scores by MCO for the 2023 MLTSS Care Management and Continuity of Care Annual Assessment Elements

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

MLTSS: Managed Long-Term Services and Supports; MCO: managed care organization.

Table 55 presents the summary of findings for each element reviewed during the 2023 MLTSS Annual Assessment Care Management audit.

Table 55: Summary of Findings for MLTSS Care Management and Continuity of Care

2023 Annual Assessment CM Element	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP
CM18b	X	X	X	X	X
CM28	X	X	X	X	X
CM29	X	X	X	X	X
CM30	X	X	X	X	X
CM31	X	X	X	X	X
CM32	X	X	X	X	X
CM34	X	X	X	X	X
CM36	X	X	X	X	X
CM37[1]	X	X	X	X	X

2023 Annual Assessment CM Element	ABHNJ	AGNJ	HNJH	UHCCP	FC/WCHP
CM38	X	X	X	X	X
Total Elements = 10	10	10	10	10	10
Compliance Percentage	100%	100%	100%	100%	100%

[1] X indicates Met, - indicates Not Met or Not Reviewed.

[1] This documentation element is reviewed annually as all elements are subject to review.

No deficiencies were identified in the MLTSS 2023 Care Management and Continuity of Care Annual Assessment Review (**Table 55**).

VIII. Focus Studies of Health Care Quality

2022 Prenatal and Postpartum Care Focus Study

Background

The need to reduce maternal morbidity and mortality is a national priority, as maternal health outcomes in the United States (US) have declined in the last few decades and continue to worsen. Notable disparities in maternal health persist across several sociodemographic characteristics, which also influence receipt of prenatal and postpartum care among low-income individuals. Further research is needed to better understand the sociodemographic disparities in the timely use of prenatal and postpartum care by Medicaid beneficiaries in NJ.

Methods

IPRO conducted a secondary analysis of data obtained from administrative member-level files for all five Medicaid MCOs in NJ for HEDIS MY 2021, January 1, 2021, to December 31, 2021. Although administrative data underestimate PPC rates compared to MCO-reported hybrid rates, county- and ZIP-code-level analysis necessitated use of the former. The primary outcomes for this study were timely prenatal care and postpartum care, as measured by subcomponents of the HEDIS Prenatal and Postpartum Care (PPC) measure: 1) Timeliness of Prenatal Care and 2) Postpartum Care, respectively.

To assess for the presence of disparities, variables that were examined in this study included: age, race/ethnicity, county, and ZIP code. Additional race/ethnicity data were derived from county health rankings and were relevant at the county level. Other community-level variables obtained from the county health rankings and explored in this study included: primary care physician (ratio), median household income ($), limited access to healthy foods (%), completed high school (%), rural residents (%), and residents not proficient in English (%). Frequency tables were developed to describe the sample in terms of the number of deliveries/birthing individuals, age group, race/ethnicity, county, and ZIP code.

Crosstabulations (contingency tables) were created to report PPC rates (Timeliness of Prenatal Care and Postpartum Care) similarly by age group, race/ethnicity, county, and ZIP code. Supplemental contingency tables reporting the distribution of members by county with the corresponding PPC rates for each race/ethnicity subgroup and for each age subgroup were generated to assess for interactions between race/ethnicity and county as well as age and county.

Other frequency tables reporting PPC rates at the ZIP-code level were produced for: PPC rates for the top-20 ZIP codes by number of live births, PPC rates for the top-20 ZIP codes (by highest performance), and PPC rates for the bottom-20 ZIP codes (by lowest performance). *Z*-scores were used to identify statistically significant differences between PPC rate population means within a 99% confidence interval (CI). Using the county health rankings, selected component measures were assessed for association with PPC rates at the county level by calculating correlation coefficients. Heatmaps were also generated using Mapbox® and OpenStreetMap® to identify sociodemographic disparities in the access and availability of prenatal and postpartum care among Medicaid beneficiaries at county level. All analyses were conducted using Microsoft® Excel® and SPSS®, version 28.0.1.1.

Key Findings

Key findings of this focus study are included here without tabular representation.

Pooled across MCOs, the analytic population comprised 24,079 MMC members who met inclusion criteria and represented 24,099 births. The mean age at time of delivery was 28.5 years (range: 12 years to 51 years), with

the majority (78.5%, 18,918) of deliveries being to members in the 20–34-year-age group. One-in-twenty (5.2%, 1,257) deliveries were to members who were younger than 20 years old. With respect to race/ethnicity, 0.1% (34) births were attributed to American Indian individuals, 23.6% (5,684) to Black individuals, 0.5% (113) to individuals who identified as Asian American or Pacific Islander (AAPI), and 36.7% (8,835) to White individuals. Almost two-fifths of the study population was identified as "Other"(13.0%, 3,131) or "Unknown" (26.2%, 6,302). Within NJ, the most represented county in the study population was Ocean (16.4%, 3,944), and the top ZIP code for live births across the state was 08701 (11.7% [data not shown]; 2,810 live births; in Ocean County). Hunterdon County had the lowest contribution to the population at 0.3% (75). More than 99.5% of deliveries were to members who resided in NJ counties, while the remaining 0.4% (106) were from out-of-state.

The study results regarding prenatal care indicated that overall, timely care occurred with 74.0% of live births using administrative data. The NJ Medicaid average, based on hybrid results reported by the five MCOs was 84.4%, which is slightly above the NCQA National average of 83.5% for HMOs reporting the PPC measure. The administrative rate of 74.0% in MY 2021 is comparable to the New Jersey State Health Assessment Data (NJSHAD) indicator rate of 75.5% for timely prenatal care in 2020.[3] In terms of age, timely prenatal visits occurred least often for births to teenage members (3 out of 5 or 62.1%), but this trend held only for Essex (65.3%), Monmouth (52.8%), and Passaic (67.7%) Counties after accounting for the population age distribution, at the county level. Similarly, timely prenatal care occurred less often for deliveries to Black members (69.0%) when compared to the total rate (74.0%) for the study population, and this finding held only in Hudson County (65.8%) after considering the racial/ethnic population distribution at the county level.

Overall, there was substantial variability in the rates of timely prenatal care by county, with the lowest being observed for Mercer County (42%) and highest for Bergen County (82.7%). There was wide variability in the timely prenatal care rates among the top-20 ZIP codes, ranging from 84.1% in ZIP code 07644 to 95.2% in ZIP code 07010. Notably, of the top-10 ZIP codes by timely prenatal care performance, 4 were in Bergen County: 07010 (95.2%), 07071 (91.9%), 07022 (89.8%), and 07621 (87.2%). Timely prenatal care rates in the bottom-20 ZIP codes ranged from 31.3% (26/83) in ZIP code 08609 to 61.5% (24/39) in ZIP code 08010. Importantly, among the bottom-20 ZIP codes for prenatal care performance, the seven lowest were found in Mercer County: 08609 (31.3%), 08618 (32.0%), 08611 (32.7%), 08648 (40.0%), 08638 (42.2%), 08629 (44.4%), and 08610 (44.9%).

Timeliness of prenatal care among MMC members may have little to do with county-level factors examined. Calculation of correlation coefficients for the relationship between timely prenatal care and various components of the county health rankings data revealed only one (weak) association (r =-0.25) with a county-level variable: percent rural. Although weak, the observed correlation was in the expected direction, i.e., MMC members in more rural settings tended to experience delays in prenatal care.

The study results for postpartum care indicated that overall, care within 7–84 days after delivery was observed in 68.2% of births. The NJ Medicaid average, based on hybrid results reported by the five MCOs was 80.4%, which was above the NCQA National average of 76.2% for HMOs reporting the PPC measure. Mirroring the pattern for timely prenatal care, a postpartum visit within 7–84 days occurred less often for births to teenagers (almost 3 out of 5 or 58.2%) compared to the overall rate in the study population, a finding which held only in Essex (46.8%) and Middlesex (52.9%) Counties after accounting for the population age distribution at the county level. Members aged 35 years and older (7 in 10 or 70.6%) were more likely to have postpartum care,

[3] New Jersey State Health Assessment Data (NJSHAD). Health Indicator Report of First Trimester Prenatal Care https://www-doh.state.nj.us/doh-shad/indicator/view/PNC1.RETrend.html .

and once the age distribution for each county was considered, this trend held only in Essex (72.5%). Similarly, postpartum visits within 7–84 days occurred less often for deliveries to Black individuals (61.5%) when compared to the total rate (68.2%) for the study population, a finding which held only in Ocean and Hudson Counties (61.8% and 62.3%, respectively) after considering the racial/ethnic population distribution at the county level. Statistically significantly higher rates of postpartum visits within 7–84 days of delivery occurred for births to White members (70.7%) and those of "Other" race/ethnicity (70.7%) when compared to the average rate (68.2%). With the ethnic/racial distribution considered, compared to the overall state-level postpartum care timeliness rate, statistically significantly higher rates of postpartum care were observed for deliveries to members of "Other" (Hudson County, 77.1%; Union County, 75.0%) or unknown (Morris County, 78.5%) race/ethnicity.

As was found with prenatal care, overall, there was substantial variability in the rates of timely postpartum care by county, with the lowest being observed for Sussex County (36.5%) and the highest for Hunterdon County (82.7%). Postpartum care showed variability in rates among the top-20 ZIP codes, ranging from 76.0% (38/50) in ZIP code 08723 to 87.9% (261/297) in ZIP code 08527. The heterogeneity of findings suggest that individual experience of care is influenced by factors outside of the county-level characteristics examined.

Among the top-10 ZIP codes for postpartum care performance, 3 were located in Ocean County: 08527 (87.9%), 08701 (84.2%) and 08755 (81.1%). Postpartum visit rates in the bottom-20 ZIP codes ranged from 29.4% (10/34) in ZIP code 07860 to 54.3% (19/35) in ZIP code 08070. Of the bottom-20 ZIP codes, 4 were in Middlesex: (08879, 08837, 08817, and 07080). There was no clear pattern emerging from an examination of the geographic distribution of the bottom-20 ZIP codes in terms of postpartum care.

Postpartum care among MMC members was weakly associated with several county-level factors as determined by correlation coefficients that were calculated for postpartum care in relation to various components of the county health rankings data, ranging between -0.32 (percent rural residence; primary care ratio) and 0.27 (percent not proficient in English). The weak correlations were found for primary care ratio, access to healthy foods, percent rural, and percent not proficient in English.

When the highest-performing ZIP codes for prenatal care were overlaid with the highest-performing ZIP codes for postpartum care, the majority were located in the mid- and north-eastern regions of the state. Five out of the top-20 ZIP codes for prenatal care also made the top-20 list for postpartum care. These were 07010, 07071, 07621, 07087 and 08083. Two of the bottom-20 ZIP codes for prenatal care were similarly in the bottom-20 ZIP codes for postpartum care, namely 08069 and 08066.

To further investigate sociodemographic disparities, the percent of Medicaid enrollees for each county was determined by comparing the county population reported in NJ's 2020 census to the *December 2020 NJ FamilyCare Managed Care Report*. A fairly consistent trend emerged showing that counties with a larger percentage of Medicaid enrollees tended to perform lower across sociodemographic and economic focus areas compared to counties with a smaller percentage of Medicaid enrollees. Heatmaps generated from county health rankings data were used to compare county health rankings to the timeliness of prenatal and postpartum care rankings. Although similarities were more prevalent in these comparisons, no clear patterns were found for prenatal care in the heatmaps. This suggests that timeliness of prenatal care is not readily explained by the county health rankings data.

It is important to note that study findings may have been impacted by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), as access to care was negatively affected during MY 2021. The study additionally had other limitations, including incomplete race/ethnicity data in the member-level files, incongruous race/ethnicity categories in the member-level files compared to the county health rankings,

inability to drill down beyond the ZIP-code level, underestimation of numerator compliant cases if compared with medical record review, and lack of data on important obstetric factors including maternal age at first pregnancy, number of pregnancies, and comorbidities.

IX. Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the state EDMU, and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2023, IPRO continues to monitor encounter data submissions and patterns.

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from Gainwell Technologies (formerly DXC Technology). IPRO loads the following data to IPRO's Statistical Analysis Software (SAS®) data warehouse: member eligibility, demographic, third-party liability information, state-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation, and vision encounter data. Starting June 2020, IPRO also began receiving a monthly supplemental pharmacy file that includes additional data elements. During 2023, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts and to ensure the monthly file receipt.

X. MCO Responses to the Previous EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Tables 56–60** display the MCOs' responses to the recommendations for QI made by IPRO during the previous EQR, as well as IPRO's assessment of these responses.

ABHNJ Response to Previous EQR Recommendations

Table 56 displays ABHNJ's progress related to the *State of New Jersey DMAHS, Aetna Better Health of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2023,* as well as IPRO's assessment of ABHNJ's response.

Table 56: ABHNJ Response to Previous EQR Recommendations

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties.	ABHNJ is contracted with the only hospital in Hunterdon County, Hunterdon Medical Center. ABHNJ is in the final stages of contracting with St. Luke's Hospital to close out our Warren County gap. We are currently having legal discussions to finalize contracting.	Addressed
The MCO should focus on improving appointment availability for adult PCPs, specialists, and behavioral health providers, as well as improve after-hours availability.	ABHNJ continues to incorporate requirement of access and availability to our providers year around to improve results. We have compared failed providers between 2021 and 2022, providers who have failed repeatedly will be addressed in our internal peer review meetings to identify next course of action.	Addressed
The plan should develop reporting that tracks grievances for the Elderly and Disabled and MLTSS subpopulations.	Grievances for the Elderly and Disabled and MLTSS subpopulations are identified through reports pulled based on rate group. The number of grievances and any trends found is reported during the monthly Appeals and Grievance Committee meetings. Information reported during the Appeals and Grievance Committee meetings is provided to Quality for ongoing monitoring.	Addressed
The MCO should ensure the review of quality metrics, including a review of complaints/quality issues, performance indicators, UM statistics or enrollee satisfaction surveys at the time of recredentialing.	The Credentialing/Recredentialing Team enhanced the current QuickBase Tool/Recredentialing Checklist to include items from CR8 - Section 4 Items A-E. Checklist will be used at the time recredentialing is completed and provide evidence that the required data/metrics were reviewed as part of the process. Provider Profile/reporting was enhanced to provide comprehensive performance and utilization metrics. Power BI Tool was developed and deployed in Q1 2023 - tool allows Recredentialing Team to access, review and include provider performance metrics as part of the recredentialing process/file. Grievances, PQOC and Critical Incidents were and continue to be reviewed as part of the recredentialing process/file. Evidence of review was added to the enhanced checklist - see above. For ongoing monitoring, Spot check review of NJ Recredentialing files to ensure enhanced checklist is complete/required data/metrics are being reviewed.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	ABHNJ demonstrated improvement in MY2021 and achieved 3.5 Star Rating by NCQA. ABHNJ submitted a 2022 HEDIS Workplan to the State for review which included a barrier analysis and interventions to address each measure that fell below the NCQA 50th percentile. An interdisciplinary HEDIS workgroup continues to meet monthly to monitor rate improvement and update the workplan on a quarterly basis. An increase in member outreach includes holding clinical events at PCP offices and the community in targeted areas with identified disparity. ABHNJ continues to work with targeted provider groups to improve member outcomes by Quality Management and Population Health Specialists by frequently meeting with providers, reviewing medical records, claims data, and member rosters to identify opportunities for improvement specific to each practice. The Plan continues to collect medical record data year-round to improve results.	Addressed
The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	The ABHNJ QM Director meets with the HEDIS/Performance Measure team to review reporting requirements as requested by IPRO and/or DMAHS. The Sr. Manager Data Engineering is on point to communicate any reporting changes to Inovolan (the Plan's certified NCQA HEDIS software vendor) to ensure accurate, timely implementation. Annually, the HEDIS/Performance Measure team reviews and defines reporting populations. Once the initial step is completed, the Sr. Manager Data Engineering is responsible for running initial queries to ensure implementation of requested changes. All subsequent analytic flowchart runs will be reviewed for continued rate accuracy. Requests from IPRO and/or DMAHS are tracked with completion due dates that allow sufficient time for quality review. The HEDIS/Performance Measure team and Quality Management Department review IPRO and DMAHS submissions together prior to submission as a final review.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	ABHNJ submitted a 2022 CAHPS Workplan to the State for review which included a barrier analysis and interventions to address each composite and measure that fell below the NCQA 50th percentile. An interdisciplinary CAHPS workgroup meets monthly to discuss the status of each intervention. The Plan's CAHPS vendor sent out pre-notification letters to members in the survey sample in 2023 and will be sending out a CAHPS informational card to all members before the 2024 survey. The Plan continues to administer a Pre-CAHPS (mock) survey via IVR to identify actionable results related to provider groups and/or geographical areas, and outreaches to providers to discuss practice specific barriers and opportunities for improvement. In addition, the Plan continues call listening sessions to listen to randomly selected to identify opportunities for improvement and will be holding meetings with Call Center leadership to implement NJ specific training to Call Center Staff serving ABHNJ members on a routine basis to discuss ABHNJ priorities, any contract changes and answer any questions the Call Center staff accordingly.	Addressed
Core Care Management Review – General	The ABHNJ care management team makes all attempts to ensure that adequate and appropriate discharge planning is occurring for all	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Population - Discharge Planning - ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed.	populations when they are hospitalized. In November of 2022, training on discharge planning occurred during a staff meeting where the managers re-educated and reviewed the discharge planning process with all care management staff which included need the priority to reach out to family and hospital discharge planners to coordinate discharge for all members/populations post discharge. To identify and facilitate discharge planning for General Population membership, the care manager team works closely with utilization management and care management is represented and attend Inpatient Rounds on a daily basis. The enterprise Readmission Avoidance Program (RAP) standard operating procedure and workflow process were updated in April 2022 to reflect NJ specific requirements that Care Management staff outreach to hospital discharge planner to ascertain discharge plan and needs during inpatient stay regardless of the readmission risk score. Previously, the Plan had followed enterprise guidelines to outreach only high risk members based on 50% or higher risk score. As part of this process, Care Management staff attempt inpatient confinement calls to speak to member/designated representative to confirm discharge plan and coordinate for any additional identified needs. The Engagement Hub has CMA staff dedicated to outreaching to the members discharged from the hospital with a low risk score. ICM CCM will continue to outreach IP members with a risk score of 50% or more. As part of the revised RAP workflow process, revisions were made to the tool that the Program Integrity (PI) staff (audit team) use to audit each CM staff on a monthly basis for adherence to desktops and job aids. The Program Integrity team began to audit on the updated process in August 2022. Managers conducted staff counseling and/or retraining as needed to individual staff falling below the 90% performance benchmark. Pregnant members are assigned to CCMs or CMAs to follow for the duration of their pregnancy. An assigned CM staff completes all maternity post discharge alerts. Engagement Hub will leverage the Disaster Float Team to assist with completion of post discharge calls to members per business needs. Care Management leadership review current staffing and workloads on an ongoing basis to determine if additional care management associates need to be added to meet contractual obligations. To further support discharge planning, the MCO identified and put into place a dedicated Transition of Care nurse beginning in June 2022. This TOC nurse assists with discharge needs for members not enrolled with active care management and refers members for ICM Care Management as appropriate. Management invited the Behavioral Health department to do a training class for the new hires and a reeducation for staff on June 19, 2023, on Behavioral Health Services that included information on discharge planning and readmission avoidance.	
Core Care Management Review – General Population - Identification of Enrollees	The Plan updated to a new CORE (Consolidated Outreach and Risk Evaluation) identification system adding additional data points to identify high risk members in Qtr. 1 of 2023. Aetna Better Health of New Jersey care management team ensured that staff were trained	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• ABHNJ should ensure that appropriate Enrollees are identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a Care Manager. • ABHNJ should ensure that appropriate Enrollees are identified by the MCO as having potential Care Management needs (applies to existing Enrollees enrolled prior to 11/16/2020 not already in Care Management).	to the new identification and stratification system. The Plan implemented changes to the Readmission Avoidance Project (RAP) in April 2022 and now outreaches to members post discharge regardless of risk score, thus identifying additional members for care management. The Plan worked with IT in December 2022 to create a monthly report of members with 3 or more inpatient admissions in a rolling 6-month period without an outreach event in the last 3 months to identify members for care management. The Plan is continuously evaluating the most efficient way to improve the IHS completion rate which will increase identification of members for care management. Members identified as high utilizers and those with unique needs are identified and outreached for care management. The Plan is currently using a multi-pronged approach including telephonic outreach, texting, IVR, Welcome Kit and non-responder mailings in effort to conduct the IHS. The Plan responds to state inquiries timely and considers this as a referral for case management. The plan established a quick base application in Qtr., 1 of 2023 to track state inquiries. The plan considers enrollees identified by IPRO as having potential CM needs for engagement in care management.	
Core Care Management Review – General Population - Identification of Enrollees Who Need Care Management – ABHNJ should ensure that the IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only), and when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only).	• ABH of NJ makes every attempt to ensure that the Initial Health Screen is completed within 45 days of enrollment for new enrollees and when such attempts are unsuccessful, aggressive outreach attempts are made within 45 days and documented. In an effort to increase screening rate performance, the plan evaluated and implemented multiple modalities to capitalize on every interaction/call with member for IHS completion including. • In January of 2023, the Plan Conducted a review of reporting to determine the time of when reach/response rates are more successful to see if outreach times warranted adjustment. After analysis, time of outreach did not influence reach rates. The Plan will continue to monitor reporting for trends. • Outreach staff were trained to use CVS Engagement Salesforce Dashboard in Q1 2023 to obtain updated contact demographics, This is in addition to the use of Care Unify, PPM, ProFax, Caremark, White Pages, Spokeo or contacting PCP for alternate contact numbers. • In addition to Welcome Calls where IHS is attempted, the Health Plan added the IHS screener to Welcome Kits on 1/12/2023 so all new enrollees receive an Initial Health Screener with a postage paid return envelope to return to plan. • IHS completion from Welcome Calls and Welcome Kits is monitored. Members who do not complete the IHS via the Welcome Call or mailed IHS receive a separate mailing, The	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	reporting used to generate this mailing moved from a monthly basis to weekly basis on 1/3/2023. • The engagement hub received an initial retraining of staff on the IHS in November of 2022 that covered timeframe and aggressive outreach requirements for screening. This is also addressed monthly during staff meetings and individually with staff during 1:1 meetings with their manager. • The plan enhanced verbiage in member handbook and placed a call out in all member newsletters moving forward to highlight IHS and need for correct member contact information. Initial publications occurred in the Elderly and Disabled Newsletter-Spring/Summer 2023 which mailed on May 23, 2023, and also the Medicaid Member newsletter Summer 2023 which mailed on May 31, 2023. • With the resumption of F2F activities, we had been planning to embed a Care Manager in the Newark HealthCare Central store to offer IHS completion to members; however, this store will not be open in the remaining months of 2023, and we are working with our Community Development leads to identify an alternate location. • For calls coming into the member services department, the MCO implemented on 1/12/2023 a phone-call wait broadcast message to remind members to complete the IHS with menu option prompts directing them to care management. The MCO set up monthly IHS reporting on 12/28/2023 which is monitored monthly for trending and analysis for opportunities. MCO is working to automate download of vendor IHS responses from data file directly into case management documentation platform and this work is ongoing.	
Core Care Management Review – General Population • ABHNJ should ensure that the initial outreach to complete the CNA is done and a CNA is completed for the enrollee. • ABHNJ should ensure that when the initial outreach is unsuccessful, aggressive outreach attempts are documented and were done within 45 days of the Enrollee's enrollment.	• Managers retrained staff on 10/26/2022 regarding the guidelines for the CNA including completeness, timeliness and the need for aggressive outreach and continue to address this as an agenda item on monthly staff meetings. • Enhancements to workflow to ensure all non-special need members that have a score of five (5) or above and/or that are deemed as having care management needs from the Initial Health Screening (IHS) are placed into the outreach queue for a CNA. • Staff received an email reminder on 11/8/2022 from leadership regarding CNA timeliness and were provided with the Care Management Workbook. These types of communications are ongoing. • Developed a weekly report to validate contacts are being completed by staff to conduct CNAs that are reviewed by management and are used for staff coaching. • The Care Management Associates (CMA), as part of the Engagement Hub, process Eliza Interactive Voice Responses to the IHS daily. The Engagement Hub Supervisor monitors staffing needs monthly to ensure sufficient member outreach capacity. The CMA role is important as timely outreach processes allow	Remains an opportunity for improvement.

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	sufficient time for the clinical care manager to engage members to complete the CNA. • ICM Managers are meeting with the Engagement Hub leadership weekly, and as needed, to identify barriers to timely outreach. • The comprehensive needs assessment desktop was updated January 12, 2023, to include language regarding adding the CNA completion to business rules, was updated on April 7, 2023, to add a timeframe for the CNA completion if a member agrees to participate and was updated on 6/12/2023 to include the method of follow up.	
Core Care Management Review – General Population – • ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source and should ensure that aggressive outreach attempts are documented to confirm EPSDT status, and the Care Manager sends EPSDT reminders. • ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. • ABHNJ should ensure that appropriate vaccines are administered for Enrollees aged 18 and above and should ensure that aggressive outreach attempts are documented to confirm immunization status for Enrollees aged 18 and above.	Aetna Better Health of New Jersey care management team works to assure that members are educated on the importance of preventive services including immunizations, vaccinations, dental care and lead testing for the general, DDD and DCP&P populations. All members engaged in care management have their gaps in care addressed by their case managers with support to coordinate needed services. Case managers send reminders for EPSDT and dental care. Staff validate data through a reliable source such as the review of claims and the state immunization site and also through aggressive outreach to providers. Detailed actions and systemic changes taken by the MCO include- ICM Management staff distribute a report which collects all immunization/preventative screenings via provider submitted claims for all members currently enrolled into care management. This report is dispersed weekly to encompass newly enrolled members as well as newly submitted claims. ICM staff review the report on a weekly basis and utilize a verifiable source to confirm that EPSDT services have been completed. Workflow documents were updated in Qtr. 4 2022 to include the need for ICM staff to conduct aggressive outreach to confirm immunization status. • Per workflow, ICM staff are to confirm that EPSDT examination is up to date and send EPSDT reminders to members and/or caregivers. The workflow was updated in Qtr. 4 2022 to include the need to conduct aggressive outreach as needed to collect the data. • ICM staff received access starting in April of 2022 and have maintained access to obtain dental records from our dental vendor, Liberty Dental. Requests are sent to Liberty Dental to grant access to newly hired staff. Per workflow, staff are to check Liberty Dental records and assist in making appointments for members as needed to address dental needs. • ICM staff all received access in 2021 and have maintained access to obtain Immunization information from the New Jersey Immunization Information System (NJIIS). Requests are sent to NJIIS to grant access to newly hired staff. Staff utilize the immunization system to verify immunization status and	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• ABHNJ should ensure that dental needs are addressed for Enrollees aged 21 and above and should ensure a dental visit occurred during the review period. • ABHNJ should ensure that the Care Manager makes attempts to obtain dental status for Enrollees aged 1 21 and those Dental reminders are sent to Enrollees aged 1 to 21. • ABHNJ should ensure that Enrollees aged 9 months to 26 months are tested twice for lead and should ensure that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.	complete focused conversations on preventive services and improvement of health outcomes. • The ABHNJ Dental Director spearheaded efforts for the vendor Liberty Dental to implement a care management team for members and beginning in April of 2022, ICM staff is able to initiate referrals onto the vendor portal for dental care coordination. • Monthly tracking of dental utilization and performance measures by the Dental Director; Liberty Dental provides a monthly report of DDD non-utilizers to follow up on non-compliance. This reporting was established in June of 2022. • ICM Staff monitor claims for Lead testing, obtain results from the child's provider, and provide education to caregivers as needed. ICM Staff educate and assist member's caregivers to ensure that the member has received two (2) Lead testing before reaching the age of 2 years old. If no lead test prior to reaching 2 years of age, ICM staff educate and/or assist the caregiver in the member receiving a blood test to confirm the lead level. The plan added a CM resource in Qtr. 1 2023 to support the increased volume of members identified for lead case management. • Beginning in Qtr. 4 2022, member specific gap in care reporting was established that is reviewed by ICM Managers and is provided to ICM staff. This reporting information related to EPSDT and immunizations. This reporting is in addition to the gaps in care already auto populated in our documentation system.	
Core Care Management Review – General Population - ABHNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD).	The ABNNJ care management team works to ensure and coordinate needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services for the General Population. Care management staff have been instructed to follow up on all referrals within 30 days. Care management staff have been instructed to document their collaboration with primary care providers, specialists, local health department, nurse and/or case workers. Detailed actions and systemic changes taken by the MCO include- ICM Staff uses available enterprise platforms such as FindHelp (formerly Aunt Bertha) to identify and coordinate referrals for community-based resources. A staff refresher on FindHelp was conducted in 10/12/2022. The enterprise platform was changed to the Community Resource Directory (CRD) in Qtr. 2 2023 and staff received related training on its use. ICM staff have been instructed to follow up on all referrals within 30 days to close the loop, this documentation includes closure of the referral event. A new referrals desktop was created and shared with staff on 9/16/2022 to reflect this update. Reporting for platform use that includes the volume of referrals and timely follow up on referrals is shared with staff on a monthly basis.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	During a team meeting on 10/26/2022, ICM staff were reeducated to contact the primary care provider for all members as part of care planning collaboration, this includes specialists as appropriate. During a team meeting on 10/26/2022, ICM staff were reeducated to contact and collaborate with Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD). Program integrity (PI) audit team conducts ongoing monthly file audits for compliance of this factor to ensure follow-up and linkages and other services are documented.	
Core Care Management Review – DDD Population - ABHNJ should ensure that Comprehensive Needs Assessment (CNA) is done and includes all required elements and should ensure that the CNA is completed timely (within 45 days of the Enrollee's enrollment).	ABHNJ incorporated actions to improve the completion of the Comprehensive Needs Assessment (CNA) Actions taken included- Managers retrained staff on 10/26/2022, 5/17/2023 and 8/14/2023 regarding the guidelines for the CNA for the DDD population including completeness, timeliness and the need for aggressive outreach and continue to address this as an agenda item on monthly staff meetings. • Staff received an email reminder on 11/8/2022 from leadership regarding CNA timeliness and were provided with the Care Management Workbook. These types of communications are ongoing. • In October of 2022, ICM updated the DDD workflow, In the past, DDD was unable to reach members who were assigned to a Care Management Coordinator for follow up bi-annually. These members are now assigned to a Clinical Care Manager for immediate continued outreach and file review to complete the CNA within 45 days of enrollment. • Developed a weekly report to validate contacts are being completed by staff to conduct CNAs that are reviewed by management and are used for staff coaching. • The Care Management Associates (CMA), as part of the Engagement Hub, process Eliza Interactive Voice Responses to the IHS daily. The Engagement Hub Supervisor monitors staffing needs monthly to ensure sufficient member outreach capacity. The CMA role is important as timely outreach processes allow sufficient time for the clinical care manager to engage members to complete the CNA. • ICM Managers are meeting with the Engagement Hub leadership weekly, and as needed, to identify barriers to timely outreach. • The comprehensive needs assessment desktop was updated January 12, 2023, to include language regarding adding the CNA completion to business rules, was updated on April 7, 2023, to add a timeframe for the CNA completion if a member agrees to participate and was updated on 6/12/2023 to include the method of follow up	Addressed
Core Care Management Review – DDD Population • ABHNJ should ensure that The Enrollee's	Aetna Better Health of New Jersey care management team works to assure that members are educated on the importance of preventive services including immunizations, vaccinations, dental care and lead testing for the general, DDD and DCP&P populations. All members	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. • ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. • ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees aged 18 and above and should ensure that aggressive outreach attempts were documented to confirm immunization status age 18 and above. • ABHNJ should ensure that a dental visit occurred during the review period for Enrollees aged 1 to 21.	engaged in care management have their gaps in care addressed by their case managers with support to coordinate needed services. Case managers send reminders for EPSDT and dental care. Staff validate data through a reliable source such as the review of claims and the state immunization site and through aggressive outreach to providers. Detailed actions and systemic changes taken by the MCO include- ICM Management staff distribute a report which collects all immunization/preventative screenings via provider submitted claims for all members currently enrolled into care management. This report is dispersed weekly to encompass newly enrolled members as well as newly submitted claims. ICM staff review the report on a weekly basis and utilize a verifiable source to confirm that EPSDT services have been completed. Workflow documents were updated in Qtr. 4 2022 to include the need for ICM staff to conduct aggressive outreach to confirm immunization status. • Per workflow, ICM staff are to confirm that EPSDT examination is up to date and send EPSDT reminders to members and/or caregivers. The workflow was updated in Qtr. 4 2022 to include the need to conduct aggressive outreach as needed to collect the data. • ICM staff received access starting in April of 2022 and have maintained access to obtain dental records from our dental vendor, Liberty Dental. Requests are sent to Liberty Dental to grant access to newly hired staff. Per workflow, staff are to check Liberty Dental records and assist in making appointments for members as needed to address dental needs. • ICM staff all received access in 2021 and have maintained access to obtain Immunization information from the New Jersey Immunization Information System (NJIIS). Requests are sent to NJIIS to grant access to newly hired staff. Staff utilize the immunization system to verify immunization status and complete focused conversations on preventive services and improvement of health outcomes. • The ABHNJ Dental Director spearheaded efforts for the vendor Liberty Dental to implement a care management team for members and beginning in April of 2022, ICM staff is able to initiate referrals onto the vendor portal for dental care coordination. • Monthly tracking of dental utilization and performance measures by the Dental Director; Liberty Dental provides a monthly report of DDD non-utilizers to follow up on non-compliance. This reporting was established in June of 2022. • ICM Staff monitor claims for Lead testing, obtain results from the child's provider, and provide education to caregivers as needed. ICM Staff educate and assist member's caregivers to ensure that the member has received two (2) Lead testing before reaching the age of 2 years old. If no lead test prior to reaching 2 years of age, ICM staff educate and/or assist the caregiver in the member receiving a blood test to confirm the	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	lead level. The plan added a CM resource in Qtr. 1 2023 to support the increased volume of members identified for lead case management. • Beginning in Qtr. 4 2022, member specific gap in care reporting was established that is reviewed by ICM Managers and is provided to ICM staff. This reporting information related to EPSDT and immunizations. This reporting is in addition to the gaps in care already auto populated in our documentation system.	
Core Care Management Review – DCP&P Population - ABHNJ should ensure Comprehensive Needs Assessment (CNA) is done and includes all required elements and the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment).	ABHNJ incorporated actions to improve the completion of the Comprehensive Needs Assessment (CNA) Actions taken included- Managers retrained staff on 10/26/2022 and May 17, 2023 regarding the guidelines for the CNA including completeness, timeliness and the need for aggressive outreach and continue to address this as an agenda item on monthly staff meetings.	Addressed
Core Care Management Review – DCP&P Population • ABHNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source and should ensure that the Care Manager sends EPSDT reminders. • ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. • ABHNJ should ensure a dental visit occurred during the review period for Enrollees aged 1 to 21 and • should ensure that the Care Manager make attempts to obtain dental status for	Aetna Better Health of New Jersey care management team works to assure that members are educated on the importance of preventive services including immunizations, vaccinations, dental care and lead testing for the general, DDD and DCP&P populations. All members engaged in care management have their gaps in care addressed by their case managers with support to coordinate needed services. Case managers send reminders for EPSDT and dental care. Staff validate data through a reliable source such as the review of claims and the state immunization site and also through aggressive outreach to providers. Detailed actions and systemic changes taken by the MCO include- • ICM staff were reeducated as to the DCPP escalation process for unable to reach DCP&P population at a team meeting on 9/23/2022. These members are escalated to the CHU nurse, DCP&P case worker, and then state representatives as part of aggressive outreach to the Resource Parent for CNA timeliness and completeness. • Staff received an email reminder from leadership regarding CNA timeliness on 11/8/2022 and were provided with the Care Management Workbook. These communications are ongoing. • Developed a weekly report to validate contacts are being completed by staff to conduct CNAs that are reviewed by management and are used for staff coaching. • The Care Management Associates (CMA), as part of the Engagement Hub, process Eliza Interactive Voice Responses to the IHS daily. The Engagement Hub Supervisor monitors staffing needs monthly to ensure sufficient member outreach capacity. The CMA role is important as timely outreach processes allow sufficient time for the clinical care manager to engage members to complete the CNA.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Enrollees aged 1 to 21. • ABHNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead. • ABHNJ should ensure that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.	• ICM Managers are meeting with the Engagement Hub leadership weekly, and as needed, to identify barriers to timely outreach. • The comprehensive needs assessment desktop was updated January 12, 2023, to include language regarding adding the CNA completion to business rules, was updated on April 7, 2023, to add a timeframe for the CNA completion if a member agrees to participate and was updated on 6/12/2023 to include the method of follow up. • ICM Management staff distribute a report which collects all immunization/preventative screenings via provider submitted claims for all members currently enrolled into care management. This report is dispersed weekly to encompass newly enrolled members as well as newly submitted claims. ICM staff review the report on a weekly basis and utilize a verifiable source to confirm that EPSDT services have been completed. Workflow documents were updated in Qtr. 4 2022 to include the need for ICM staff to conduct aggressive outreach to confirm immunization status. • Per workflow, ICM staff are to confirm that EPSDT examination is up to date and send EPSDT reminders to members and/or caregivers. The workflow was updated in Qtr. 4 2022 to include the need to conduct aggressive outreach as needed to collect the data. • ICM staff received access starting in April of 2022 and have maintained access to obtain dental records from our dental vendor, Liberty Dental. Requests are sent to Liberty Dental to grant access to newly hired staff. Per workflow, staff are to check Liberty Dental records and assist in making appointments for members as needed to address dental needs. • ICM staff all received access in 2021 and have maintained access to obtain Immunization information from the New Jersey Immunization Information System (NJIIS). Requests are sent to NJIIS to grant access to newly hired staff. Staff utilize the immunization system to verify immunization status and complete focused conversations on preventive services and improvement of health outcomes. • The ABHNJ Dental Director spearheaded efforts for the vendor Liberty Dental to implement a care management team for members and beginning in April of 2022, ICM staff is able to initiate referrals onto the vendor portal for dental care coordination. • Monthly tracking of dental utilization and performance measures by the Dental Director; Liberty Dental provides a monthly report of DDD non-utilizers to follow up on non-compliance. This reporting was established in June of 2022. • ICM Staff monitor claims for Lead testing, obtain results from the child's provider, and provide education to caregivers as needed. ICM Staff educate and assist member's caregivers to ensure that the member has received two (2) Lead testing	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	before reaching the age of 2 years old. If no lead test prior to reaching 2 years of age, ICM staff educate and/or assist the caregiver in the member receiving a blood test to confirm the lead level. The plan added a CM resource in Qtr. 1 2023 to support the increased volume of members identified for lead case management. • Beginning in Qtr. 4 2022, member specific gap in care reporting was established that is reviewed by ICM Managers and is provided to ICM staff. This reporting information related to EPSDT and immunizations. This reporting is in addition to the gaps in care already auto populated in our documentation system.	
MLTSS - HCBS 2022 Care Management Review – Assessment - Group D: Aetna should ensure that a Screening Community Service Assessment (SCS) is utilized to identify potential MLTSS needs and is submitted to DoAS by the 10th of the month following completion of the SCS.	Aetna has deep dived the assessor process and implemented a QuickBase tool to monitor timeliness for MLTSS referrals and SCS completion, staff reeducation completed. Assessors utilize a task list in Dynamo that assists with maintaining timeliness. Director and Assessor Supervisor review and submit to DoAS by the 10th of each month.	Addressed
MLTSS - HCBS 2022 Care Management Review – Member Outreach - Group D: Aetna should ensure that the Care Manager contacts the Member telephonically to conduct a Screening for Community Services assessment and completes the Plan of Care within forty-five (45) calendar days of enrollment notification.	Aetna has deep dived the assessor process and implemented a QuickBase tool to monitor timeliness for MLTSS referrals and SCS completion. Aetna implemented internal turnaround time of 30 days to complete initial face to face visit and complete initial plan of care. This is monitored via the Dashboard to ensure timeliness of initial visits and ensures any members being seen past 30 days has a valid, member-driven reason documented in the file.	Addressed
MLTSS - HCBS 2022 Care Management Review – Telephonic Monitoring • Group C: Aetna should ensure that Options Counseling was provided to the Member and if participant direction was selected, the application package is submitted within thirty (30) business days of	Aetna updated the Participant Direction and Personal Preference Program Job Aide to indicate CM must task self to follow up on application completion in an effort to ensure application packets are submitted as per required timelines. Aetna utilizes a QuickBase program to track and improve PPP compliance. Aetna leadership meets biweekly with the PPP Team in a workgroup to review PPP daily operations, PPP timeliness, and PPP improvement opportunities. Reeducation on Cost Effectiveness was completed with the care management team. Workflows were updated to direct staff to complete new CES initially, annually, and with any change in service.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
completion. Aetna should ensure Members have a cost neutrality analysis on file during the review period and includes a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage. • Group D: Aetna should ensure that Options Counseling was provided to the Member and if participant direction was selected, the application package is submitted within thirty (30) business days of completion. • Group E: Aetna should ensure that Options Counseling was provided to the Member and if participant direction is selected, the application packages are submitted within thirty (30) business days of completion. Aetna should ensure Members have a cost neutrality analysis on file during the review period and includes a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations.	
MLTSS - HCBS 2022 Care Management Review – Initial Plan of Care and Ongoing Plans of Care (Including Back-up Plans)- Group D: Aetna should ensure that the Member	Care managers were reeducated on importance of completing initial visits timely. Aetna implemented internal turnaround time of 30 days to complete initial face to face visit and complete initial plan of care. This is monitored via the Dashboard to ensure timeliness of initial visits and ensures any members being seen past 30 days has a valid, member-driven reason documented in the file. Metrics are measured by the Aetna audit team. For any CM who averages below	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
has a completed signed or verbally acknowledged Plan of Care that is provided to the Member and/or Member representative within 45 days of enrollment into the MLTSS program. Aetna should ensure that the Member was assessed for PCA services within 45 days of enrollment into MLTSS. Aetna should ensure for those Members requiring a Back-up Plan, that the Back-up Plan is signed/verbally acknowledged (not applicable for Members residing in CARS). Aetna should ensure that Members identified as having a potential risk have a signed/verbally acknowledged Risk Management Agreement with all of its components (not applicable for Members residing in CARS). Aetna should ensure the Member file contains a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member has received his/her rights and responsibilities in writing, that these rights and responsibilities have been explained to the Member, and that the Member understands them.	90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations.	
MLTSS - HCBS 2022 Care Management Review – Ongoing Care Management	Group C: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• Group C: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members who were enrolled long enough for a quarterly update and have services that required a Back-up Plan, have the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure for Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge. • Group D: Aetna should ensure that if a	to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members who were enrolled long enough for a quarterly update and have services that required a Back-up Plan, have the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure for Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge. Group D: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge. Group E: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The	Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge. Care management staff reeducated regarding Service Interruptions, updated process for resolving member issues related to delay or interruption of services. Reeducation completed regarding unmet supports and the importance of documentation of such in the member chart. Reeducation regarding Money Follows the Person and contractual requirement to outreach members telephonically following transitions from community to NF. Reeducation occurred regarding Service Decision Review, in which member disagrees with a service and the member receives written notice of action/ written details on the appeal process. Care managers utilize the Dashboard and their task list in Dynamo to maintain timeliness and organization regarding member needs. Supervisors review task lists for timeliness and review in care managers one-to-one meetings. Unmet Support process was updated to streamline referrals for service providers and improve efficiency. Reeducation on compliance with visit timeliness, review of backup plan and POC at least quarterly for HCBS members. The MLTSS Support Team (care management associates) contacts members within one week of authorization to confirm service initiation and member satisfaction. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations. Transition Liaison hosts biweekly NF Transition case rounds during which transitions are discussed, supervisors maintain oversight for compliance and timeliness of associated transition.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge. • Group E: Aetna should ensure that if a Member file has documented issues that impede access to care there is sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period. The Plan should ensure timely Member telephonic visits to review placement and services (an ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). The Plan should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) are counseled by the Care Manager about a written notice		

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
of action that explains the Member's right to file an appeal. The Plan should ensure Members who are enrolled long enough for a quarterly update and have services that require a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis. The Plan should ensure Members discharged from an institutional facility to a HCBS have documentation that a Care Manager conducted a telephonic visit within ten (10) business days of the documented date of discharge.		
MLTSS - HCBS 2022 Care Management Review – Performance Measures • Group C: PM #10: Aetna should ensure the Member's Plan of Care aligns with the needs identified on the NJ Choice Assessment and the Plan of Care is signed or verbally acknowledged by the Member and/or authorized representative. • Group C: PM #11: Aetna should ensure the Member's Plan of Care developed using "Person-Centered principles" is signed or verbally acknowledged by the Member and/or authorized representative.	Performance Measure 10: Group C: Aetna should ensure the Member's Plan of Care aligns with the needs identified on the NJ Choice Assessment and the Plan of Care is signed or verbally acknowledged by the Member and/or authorized representative. Reeducation focused on the importance of member POC aligning with the needs assessed on the NJ Choice Assessment. Annual training on PCA held during which full demonstration of PCA assessments and case study were presented to demonstrate how NJCA relates to PCA Assessment. CM reeducated on importance of Member File Review and need for follow up with unsigned documents from previous visits. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations. The MLTSS Support Team (care management associates) review list of members who did not sign POC at face-to-face visit and complete follow up in attempt to obtain signature. Performance Measure 11: Group C: Aetna should ensure the Member's Plan of Care developed using "Person-Centered principles" is signed or verbally acknowledged by the Member and/or authorized representative.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• Group D: PM #12: Aetna should ensure that the MLTSS Home and Community-Based Services (HCBS) Plans of Care contain a Back-up Plan that is signed or verbally acknowledged by the Member and/or authorized representative.	Reeducation completed regarding person-centered goals, providing person-centered care, Member File Review, and obtaining member/ representative signatures. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations. The MLTSS Support Team (care management associates) review list of members who did not sign POC at face-to-face visit and complete follow up in attempt to obtain signature. Performance Measure 12: Group D: Aetna should ensure that the MLTSS Home and Community-Based Services (HCBS) Plans of Care contain a Back-up Plan that is signed or verbally acknowledged by the Member and/or authorized representative. Care managers reeducated on Service Interruptions, implementing backup plan, and importance of obtaining signatures on backup plan. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations. The MLTSS Support Team (care management associates) review list of members who did not sign POC at face-to-face visit and complete follow up in attempt to obtain signature. Workflows indicate that care manager must review charts for documents requiring signature and make attempts to obtain signatures on past documents.	
MLTSS - NF/SCNF 2022 Care Management Review – Initial Plan of Care and Ongoing Plans of Care – The Care Manager should ensure that Member's Plan of Care is reviewed, revised if applicable for any significant changes, and confirm the agreement/disagreement statement is reviewed and signed by the Member/POA.	Care management staff were reeducated on the Significant Change in Condition process, including the requirement for member POC to be updated, review, and signed by the member and/or representative at every significant change in condition visit. The MLTSS Support Team (care management associates) review list of members who did not sign POC at face-to-face visit and complete follow up in attempt to obtain signature. Workflows indicate that care manager must review charts for documents requiring signature and make attempts to obtain signatures on past documents. Workflows indicate that care manager must review charts for documents requiring signature and make attempts to obtain signatures on past documents. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations.	Addressed
MLTSS – NF/SCNF 2022 Care Management Review	Care managers were reeducated on requirement to attend at minimum 1 IDT annually per calendar year and suggestions for IDT	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
– Transition Planning - The MLTSS Care Manager should confirm there is documentation of the Member's participation in at least one Facility IDT meeting annually	completion/ successful discussion with NF Team. MLTSS Leadership receives a report weekly from Informatics detailing the number of IDT completed per week. The report is processed, trends identified, and shared with MLTSS Leadership. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations. Transition Liaison hosts biweekly NF Transition case rounds during which trends are discussed and areas for improvement are strategized.	
MLTSS – NF/SCNF 2022 Care Management Review - Performance Measure 9a - Aetna's MLTSS Care Managers should ensure plan of care for MLTSS members are updated based on change in member condition.	Care managers were reeducated on need to update POC when a member has a change in placement, as well as the requirement to conduct face-to-face visit within 10 calendar days of a member's change in placement/ change in condition to amend the plan of care. Transition Liaison hosts biweekly NF Transition case rounds during which transitions are discussed, supervisors maintain oversight for compliance and assurance that POC are being updated for change in conditions. Metrics are measured by the Aetna audit team. For any CM who averages below 90% for the month, an individualized remediation session is held with the CM and the Supervisor in which areas of deficiency are reviewed/ reeducated on. Further sessions with the Nurse Educator as scheduled as needed in addition to field observations.	Addressed

[1] **Addressed**: Managed care organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2024. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

AGNJ Response to Previous EQR Recommendations

Table 57 displays AGNJ's progress related to the *State of New Jersey DMAHS, Amerigroup New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2023,* as well as IPRO's assessment of AGNJ's response.

Table 57: AGNJ Response to Previous EQR Recommendations

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
AGNJ should address the PIP validation elements that were determined to be not met or partially met.	Amerigroup continues performance improvement project (PIP) specific work groups with dedicated staff leads within its operational teams. These PIP work groups collaborate with the Quality Management (QM) Department and a dedicated physician, to support the analysis and evaluation of all PIP activities. A data analytics team is leveraged to expand data collection, produce analytic and monitoring trend reports, to ensure a more robust assessment is performed for PIP initiatives against stated goals, aims, and objectives for each PIP. PIP specific work groups perform a quarterly data review and deep-dive analysis for PIP initiatives and applicable performance measures. This deep-dive analysis allows for the PIP to be evaluated for any opportunities for	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	additional analytic reporting options to be developed to further support PIP intervention measurement and tracking. Amerigroup also maintains a PIP monitoring workplan to track interventions and data/reporting needs and to ensure accountability for oversight of interventions and data deliverables. In 3Q 2022, Amerigroup instituted a Quality Department peer-to-peer review process for all Core and MLTSS PIP submissions to ensure accuracy of reporting across all sections of PIP submissions. This additional peer review process offers an additional data quality and content review process so that PIP information is presented in an accurate, concise manner, while identifying rationale for changes, and evaluating appropriate table changes have occurred throughout the PIP submission. Amerigroup will continue to monitor/evaluate its PIP process for opportunities for improvement.	
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County.	Hunterdon Medical Center is the only hospital in this county and employs most of the physicians. Amerigroup has contracted with Hunterdon Medical Center which will improve access to care for adult PCPs in Hunterdon County. Contract went into effect on 8/1/2023. Amerigroup is currently in the process of credentialing with Hunterdon.	Addressed
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Warren County.	St. Luke's Warren Hospital owns the vast majority of PCP practices in Warren County. Amerigroup has contracted with St. Luke's Warren Hospital which will improve access to care for pediatric PCPs in Warren County. Contract went into effect on 12/16/2022. Amerigroup is currently in the process of credentialing with St. Luke's.	Addressed
The MCO should continue to address hospital deficiencies in Hunterdon and Warren Counties.	Amerigroup has contracted with Hunterdon Medical Center and St. Luke's Warren Hospital to improve access in Hunterdon and Warren Counties.	Addressed
The MCO should focus on improving appointment availability for OB-GYNs, Other Specialists, Urgent Specialty care, Behavioral Health Prescribers, Behavioral Health Non-Prescribers as well as after-hours non-compliance.	Providers are educated about Appointment Availability and After-Hours Standards via provider newsletters and ongoing provider training conducted by the Provider Experience team. Starting Q1 2024, Amerigroup is increasing the frequency of Appointment Availability and After Hour surveys from annually to bi-annually. Amerigroup is also reviewing the survey scripts for potential editing to improve clarity of questions and expectations for providers in terms of access to care. Member grievances concerning availability are addressed with providers by the Provider Experience team. Health Care Management is available to assist Members with appointment scheduling.	Addressed
The MCO should ensure the Community/Health Education Advisory Committee is held quarterly and evidence of the meeting is documented.	During the 2022 Annual Assessment a Corrective Action Plan was received related to the holding of quarterly meetings. During the reporting period the advisory meetings were held quarterly; meetings which were held quarterly during the audit period: Q3 2023 - July 20, 2022; Q4 2022 - November 4, 2022; Q1 2023 - February 23, 2023 and Q2 2023 - April 26, 2023. Meetings are documented through minutes and sign in sheets.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should ensure the MLTSS Consumer Advisory Committee is held quarterly and evidence of the meeting is documented.	During the 2022 Annual Assessment a Corrective Action Plan was received related to the holding of quarterly meetings. During the reporting period the advisory meetings were held quarterly; meetings which were held quarterly during the audit period: Q3 2023 - July 20, 2022; Q4 2022 - November 4, 2022; Q1 2023 - February 23, 2023 and Q2 2023 - April 26, 2023. Meetings are documented through minutes and sign in sheets.	Addressed
The MCO should ensure that policies provided contain all Contract requirements.	MCO Response: All Amerigroup policies undergo an annual review. Ad hoc policy reviews may be performed more frequently as needed. Contractual references are confirmed as part of the policy review process. Amerigroup has confirmed that all policies contain all applicable contract requirements.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, AGNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Amerigroup routinely monitors and leverages HEDIS reporting to evaluate its performance against the NCQA 50th percentile. Amerigroup maintains a HEDIS intervention work plan, which identifies barriers and monitors interventions. Intervention success or deficiencies are reviewed monthly and quarterly. Amerigroup also collaborates within various departments (i.e., Medical Affairs, Member Engagement, Provider Experience, Pharmacy, Healthcare Services, BH (Behavioral Health), EPSDT (Early Periodic Screening and Diagnostic Testing) teams) through the HEDIS workgroup, and via targeted member and provider engagement initiatives. The HEDIS workgroup is leveraged to create, improve and/or modify interventions in the work plan or identified through HEDIS performance analytic reporting, with the goal of addressing gaps in care and improving members' health outcomes for HEDIS measures, to meet and/or exceed the NCQA 50th percentile. Amerigroup also partners with our delegated vendors (i.e., Liberty Dental and Versant Health (formerly Superior Vision) to develop initiatives that drive improved performance for related HEDIS measures (i.e., Annual Dental Visit (ADV- Retired MY2023), and Eye Exam for Patients with Diabetes (EED)). Some multi-year measures continued to see residual effects from members delay in accessing medical services due to the COVID-19 pandemic (i.e., well-care visits for members between 15-30 months and vaccination rates in Childhood Immunization Status (Cis-Combo 10, and Immunizations for Adolescents (IMA- Combo 2). Quarantines and fear of contracting the virus contributed to many members not seeking timely routine care during the pandemic. Amerigroup has continued to monitor this residual effect and has seen consistent improvement in member engagement and compliance across multiple HEDIS measures overall. Amerigroup had historically sent generic text messages in member text campaigns for multiple measures. However, Amerigroup has re-evaluated this approach and revised several member text message campaigns to offer more tailored and interactive text messages for several HEDIS measures. The new interactive text message campaigns expanded member education around specific	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	measures in the hopes of improving member engagement for accessing preventive services. Amerigroup will continue to monitor the HEDIS workplan's performance and the associated member and provider initiatives, for continued improvement across HEDIS measures.	
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	Amerigroup has developed a workplan which includes interventions to improve on those measures that have fallen below the 50th percentile. These interventions are outlined in the workplan that was submitted to DMAHS on August 14, 2023. In addition to interventions which will be continued from previous years, the following new interventions will be implemented in 2023: 1. Create a work group of associates that interface with members to identify strategies for improving various levels of dissatisfaction with their health care. 2. Conduct small member focus groups to better understand ways Amerigroup can improve member satisfaction. 3. Ensure that Customer service representatives (National Call Center staff) have the necessary and accurate information needed to serve members. 4. Partner with Community based organizations to hold "Community Conversations" in counties/with member groups that are historically low utilizers of health care services. 5. Create a social media campaign focused on member satisfaction and preparing for your doctor's visit. 6. Include provider education relating to member satisfaction at provider quarterly webinars.	Addressed
Core Care Management Review – General Population - AGNJ should ensure that for the Enrollees who were hospitalized, adequate discharge planning is performed.	Discharge Planning: PDM (Post Discharge Management) cases are audited weekly by the Manager and Lead Care Manager (CM) or designee for adherence to PDM process. In addition to above, Manager is attending daily inpatient clinical rounds to determine appropriate referrals for monitoring. Two additional CMs hired to manage discharge planning.	Addressed
Core Care Management Review – General Population AGNJ should ensure that Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2020) are assigned and followed by a care manager.	Identifying Potential CM Needs: Manager is attending daily inpatient clinical rounds to determine appropriate CM referrals for monitoring. CM cases are audited weekly by the Manager and Lead CM or designee for adherence to CM process. Two additional CMs hired to manage discharge planning where members with potential CM needs can be identified and referred to internal CM programs.	Addressed
Core Care Management Review – General Population	Timely Completion of IHS and CNA for New Enrollees: Manager is monitoring number of completed IHSs and CNAs monthly. Manager is also monitoring the aggressive outreach report (this report	Remains an opportunity for improvement

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• AGNJ should ensure that the IHS is completed for the enrollee within 45 days of enrollment (applies to new enrollees only). • AGNJ should ensure that Initial outreach to complete a CNA was done and completed for the enrollee.	identifies members who scored 5 or greater on IHS and the auto dialer was not able to contact). Outreach is continuing for 12 months to attempt to complete a CNA for both General and DDD populations.	
Core Care Management Review – General Population • AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, ensure that aggressive outreach attempts are documented to confirm EPSTD status, and the Care Manager sends EPSDT reminders. • AGNJ should ensure that the Enrollee's immunizations are up to date for Enrollees aged 0-18, confirmed by a reliable source and aggressive outreach attempts are documented to confirm immunization status. • AGNJ should ensure that appropriate vaccines are administered for Enrollees aged 18 and above and that aggressive outreach attempts are documented to confirm immunization status.	Continuity of Care (Preventive Services): Manager has educated and re-educated CM team on specific documentation and updated audit tool related to all education provided to members. Manager developed a reliable source preventive services summary note to ensure CM staff addressed these services.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• AGNJ should ensure that dental needs are addressed for Enrollees aged 21 and above. • AGNJ should ensure a dental visit occurred during the review period for Enrollees aged 1 to 21, • the Care Manger makes attempts to obtain dental status for enrollees and those dental reminders are sent to enrollees aged 1 to 21. • AGNJ should ensure that Enrollees aged 9 months to 26 months are tested twice for lead. • AGNJ should ensure that Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test. • AGNJ should ensure that the Care Manager makes attempts to obtain lead status for Enrollees aged 9 months to 72 months and sends lead screening reminders.		
Core Care Management Review – General Population • AGNJ should ensure that when appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs,	Documentation of Contacts and Linkages to Services: CM audits are being completed by Manager and/or CM lead monthly for six (6) months to ensure proper documentation of provider contacts and community linkages. If audits are satisfactory, audits will resume on a quarterly and ad hoc audit schedule.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
specialists, and the local health department (LHD). • AGNJ should ensure that the Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, discharge planning if hospitalized, pharmacy and other support services as appropriate for the Enrollee and are noted in the Enrollee's case files.		
Core Care Management Review – DDD Population - AGNJ should ensure that the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	Timely Completion of CNA for New DDD Enrollees: Manager is monitoring number of completed CNAs monthly. Manager is also monitoring the aggressive outreach report. Outreach is continuing for 12 months to attempt to complete a CNA for DDD members.	Addressed
Core Care Management Review – DDD Population - AGNJ should ensure that the Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	Plan of Care: Manager is ensuring cases that are open/active to care management have a Plan of Care and include all required components and is being developed within 30 days of CNA completion. Manager is contacting assigned CM when there is a missing care plan. Manager is also monitoring for Care Plan completion, and changes when appropriate by reviewing the Tracker Report monthly.	Addressed
Core Care Management Review – DDD Population - • AGNJ should ensure that the appropriate vaccines have been administered for Enrollees aged 18 and above. • AGNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead.	Continuity of Care (Preventive Services): Manager has educated and re-educated the Care Manager (CM) team on specific documentation and updated audit tool related to all education provided to members. Manager developed a reliable source preventive services summary note to ensure CM staff addressed these services.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• AGNJ that the Enrollees who had never previously been tested for lead before 24 months of age received a blood lead test.		
Core Care Management Review – DCP&P Population • AGNJ should ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. • AGNJ should ensure that The Enrollee's immunizations are up to date for Enrollees aged 0-18 and immunization status is confirmed by a reliable source. • AGNJ should ensure that A dental visit occurred during the review period for Enrollees aged 1 to 21. • AGNJ should ensure that Enrollees aged 9 months to 26 months were tested twice for lead. • AGNJ should ensure that Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test.	Continuity of Care (Preventive Services): Manager has educated and re-educated CM team on specific documentation and updated audit tool related to all education provided to members. Manager developed a reliable source preventive services summary note to ensure CM staff addressed these services.	Addressed
AGNJ should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86% - Member Outreach	Group C: Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program. MCO Response: Amerigroup has dedicated staff conducting initial outreaches on all new enrollees to MLTSS within 5 business days with the intent to schedule a visit with the member and their assigned Care Manager for the development of the Plan of Care.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	The Initial Outreach tracking is uploaded to a shared site with the dedicated staff and the compliance team. A Clinical Compliance Manager has been assigned to review the Initial Outreach compliance on a daily basis and follow up with designated staff and clinical managers regarding Initial Outreach compliance and areas of risk. Risk for non-compliance is identified by Day 3 of the initial outreach and additional resources are pulled in to complete outreaches within contractual timeframes, as necessary.	
AGNJ should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86% - Ongoing Care Management	Group C (1-3 below); Group E (2-4 below) 1. Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation). MCO Response: Amerigroup utilizes the Daily Snapshot report as well as the Due/Overdue Plan of care report to monitor Care Manager metrics, including compliance with contractual timeframes for visit timeliness. In addition, the Daily Snapshot report has been updated to identify upcoming visits that are due per Care Manager. This provides increased visibility to the clinical managers to proactively identify areas of risk and follow up with those Care Managers accordingly. Amerigroup has added completion of the post orientation outreach for confirmation of MLTSS services within contractual timeframes to the Internal Audit process. Ongoing internal auditing addresses compliance to this element in real time allowing the Clinical Compliance Team to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. 2. Telephonic visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being. MCO Response: Amerigroup has a dedicated compliance manager that monitors daily census reports for hospital admissions and discharges in order to follow the member through any institutional stay. This is shared with the Medical Management Specialist team who then alerts the appropriate Care Manager in the Healthy Innovations Platform (HIP) system with a 24 hour call back request. In addition, the Clinical Managers monitor 24 hour call back tasks daily in HIP and follow up with Care Managers if risk for non-compliance is identified. In addition, element specific reporting related to 24 hour call back tasking has been requested with an expectation to roll out in Quarter 1 2024. 3. Member file indicated a discharge from an institutional facility to a HCBS had documentation that a telephonic visit was done by a Care Manager within ten (10) business days of the documented date of discharge. MCO Response: Amerigroup has implemented a second CRR3 position in addition to an LTSS Concierge Coordinator to ensure	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	members that have discharged from an institutional facility to a HCBS setting have a visit completed within 10 business days from the discharge date. Nursing facility transition workflows have been developed and updated to reflect appropriate documentation and timely post discharge visit requirements. The LTSS Concierge Coordinator works alongside the primary Care Manager to ensure post discharge visit is completed and all member needs are met in the community. In addition, the Clinical Compliance Team will monitor visit timeliness and appropriate documentation following the member's discharge from an institutional facility via the Internal Audit Process. Ongoing internal auditing addresses compliance to this element in real time allowing the Clinical Compliance Team to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. The care management department has received re-education regarding documentation within 10 business days of an HCBS member's documented date of discharge from an institutional facility on 7/27/23. 4. Member had a documented telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). MCO Response: Amerigroup utilizes the Daily Snapshot report as well as the Due/Overdue Plan of care report to monitor Care Manager metrics, including compliance with contractual timeframes for visit timeliness. The Daily Snapshot report has been updated to identify upcoming visits that are due per Care Manager. This provides increased visibility to the clinical managers to proactively identify areas of risk and follow up with those Care Managers accordingly. In addition, ongoing internal auditing addresses compliance to this element in real time allowing the Clinical Compliance Team to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers.	
AGNJ should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86% - Initial Plan of Care (Including Back-up Plans)	Group D Member was assessed for PCA services within 45 days of enrollment into MLTSS. MCO Response: The Clinical Managers utilize the Daily Snapshot report to track PCA Tool completion. This report is distributed on a daily basis and provides visibility to the clinical managers to clearly identify if members have had a PCA Tool completed within 45 days of MLTSS enrollment. The Clinical Managers will reach out to those Care Managers at risk for non-compliance with this element. Care Management staff have been re-educated on 6/29/23 regarding this element. In addition, ongoing internal auditing addresses compliance to this element in real time allowing the Clinical Compliance Team to trend data, and provide department level re-	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. PCA re-assessment was completed for changes in the Member's condition or living arrangements. MCO Response: Amerigroup has added this element to the Internal Audit process to ensure PCA Tool completion for those members that have had a change in condition or living arrangement. This provides Clinical Managers with an additional data source to utilize when completing ongoing case review and re-education to staff. In addition, Desktop Processes have been updated to reflect PCA Assessment Tool completion requirements upon significant change in condition and/or living arrangement changes. Care Management staff have been re-educated on 5/12/23 regarding this element and ongoing internal auditing will address compliance to this element in real time and trend data. This data is shared with the clinical managers to follow up with Care Managers, as appropriate. Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them. MCO Response: The MLTSS Member Handbook includes the Member's Rights and Responsibilities, which is mailed to the member upon initial outreach and annually. The Rights and Responsibilities are included within the MLTSS Plan of Care and are signed by the member at each visit upon completion of the Plan of Care. The Plan of Care is mailed to the member following each visit inclusive of the Rights and Responsibilities signature page. Re-education provided to Care Managers regarding documentation of members receipt and understanding of their Rights and Responsibilities was completed 6/23/2022 and 7/27/23. In addition, Amerigroup has added this element to the internal auditing process to trend the completion of documentation of member's understanding of their Rights & Responsibilities and MLTSS Plan of Care mailing. This provides Clinical Managers with an additional data source to utilize when completing ongoing case review and re-education to staff.	
AGNJ should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86% - Telephonic Monitoring or Face-to-Face Visits	Group E Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion. MCO Response: Amerigroup has a designated associate who monitors receipt of new participant direction requests daily. The designated associate will maintain and track this information on a SharePoint site and includes, but is not limited to, the following information: the date when the service referral is received, date the application was completed by Care Manager, date the application	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	was submitted to PPL. The Self- Direction Program Administrator provides ongoing monitoring in regards to the submissions of new referral applications. Re-education has been provided to those associates assisting with processing new referrals to ensure that the 30-day contractual requirement is met. In addition, State Enrollment reports are completed quarterly and is used as an additional opportunity to ensure that contractual requirement were being met and if non-compliance is identified, the program administrator will conduct a root cause analysis and will follow up with the associate accordingly. To date, referrals are submitted within 15 days on average. Member had a cost neutrality analysis on file during the review period and included a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage. MCO Response: Upon the initial visit, change in services and at least annually, Care Managers complete a cost neutrality analysis which includes a calculation of the member's annual cost thresholds and then uploads it into the Healthy Innovations Platform (HIP) system. Care Managers are educated upon hire and annually regarding the requirement for a cost neutrality analysis to be on file in the member's record upon initial visit, change in services and at least annually. The Clinical Compliance Team monitors the completion and validity of the cost neutrality analysis via the Internal Auditing process. In addition, re-education was provided to the care management department on 9/29/2022 on 7/27/2023.	
AGNJ should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86% - MLTSS Initial Plan of Care and Ongoing Plans of Care.	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. MCO Response: For any significant change in member's condition, the Care Manager updates and reviews the plan of care with the member and ensures it is signed by the Member and/or representative. The Care Manager will mail a copy of the updated plan of care through the Healthy Innovations Platform (HIP) system to the Member and/or representative. Care Managers receive annual training regarding significant change in member condition requirements including ensuring the plan of care is updated, reviewed, signed and a copy is mailed to the member and/or representative. Additional resources have been developed for the Care Management team as an added educational layer to outline a member's decline/improvement in status, change of living arrangement and/or level of care, and hospitalizations that may result in a change of functional status. Amerigroup has also added this element to the Internal Auditing process to trend data related to POC completion, review, signature and mailed copy for members with a significant change in status. This provides Clinical Managers with an additional data source to utilize when completing ongoing case review and re-education to staff.	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
AGNJ should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86% - Plan of Care in an Institutional Setting Transition Planning	Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting MCO Response: Amerigroup utilizes designated associates to request the most current facility IDT documentation for Care Managers to review with member/representative and facility staff. Designated associates will also schedule a 6 month and 12 month task in the Healthy Innovations Platform (HIP) system to alert the Care Manager to follow up with this requirement. The Clinical Managers review their teams' dashboard monthly to identify any areas of risk and follows up with Care Managers, as applicable. Care Managers receive annual training and resources for the participation in at least one Facility Interdisciplinary Team (IDT) meeting. Ongoing internal auditing addresses compliance to this element in real time allowing the Clinical Compliance Team to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. In addition, element specific reporting related to Care Manager's participation in at least one facility Interdisciplinary Team (IDT) meeting has been requested with an expectation to roll out in Quarter 1 2024. Care Manager explained and discussed any payment liability MCO Response: Amerigroup has designated a specific area on the Plan of Care for documentation of payment liability discussion and review with the member. Care Managers receive annual training in regards to compliance with this element. Internal auditing is completed on a monthly basis for each of the Care Managers, which includes a review of the Care Manager discussing patient liability with the member. The compliance team will send out monthly reports demonstrating trends per Care Manager for further follow up. Care Managers who fail to meet this element will be tasked in HIP to follow up on this element. In addition, re-education to the care management staff was provided on 7/6/23. The Clinical Compliance Team will continue to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers. Results of MLTSS Performance Measure #9a: AGNJ Member's Plan of Care is amended based on change in member condition. MCO Response: For any change in member's condition, the Care Manager updates and review the plan of care with the member/representative. Care Managers receive annual training and resources regarding making amendments to the member's Plan of Care based on changes in member's condition. Additional resources have been developed for the care management team as an added educational layer to outline a member's	Addressed

Recommendation for AGNJ	AGNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	decline/improvement in status, change of living arrangement and/or level of care, and hospitalizations that may result in a change in functional status. The compliance team will send out monthly reports demonstrating trends per Care Manager for further follow up. The Clinical Compliance Team will continue to trend data, and provide department level re-education, as needed, while the Clinical Management Team addresses areas of opportunity with individual Care Managers.	

[1] **Addressed**: Managed care organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2024. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

FC/WCHP Response to Previous EQR Recommendations

Table 58 displays WCHP's progress related to the *State of New Jersey DMAHS, WellCare Health Plans of New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2023,* as well as IPRO's assessment of WCHP's response.

Table 58: FC/WCHP Response to Previous EQR Recommendations

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
WellCare should address the PIP validation elements that were determined to be not met or partially met.	WellCare has addressed the PIP validation that were not met with the following: a. FC/WCHP Core Caid EPSDT PIP - WellCare has updated the baseline to the required W30 for 2021 due to the HEDIS Measure change during MY 2020 expanding W-15 to W-30 to include 0- 30 months of well child visit and immunizations requirements. All data has been revised to reflect 2021 as baseline, including Aim Statement, Objectives, and Goals. PIP Score: 75% b. FC/WCHP Medicaid PCP Access and Availability PIP – The footnotes now fully explain how the MCO calculates numerator/ denominator equaling visits/1000 when the calculation for the rates is displayed as N/D *1200. The MCO also provided clarification to the footnotes cited below Table 2 for Indicators #3 and #4 as well as in the Data Collection and Analysis Procedures section. PIP Score: 90.6% c. FC/WCHP Improving Coordination of Care FUH MLTSS PIP – WellCare has signed the attestation and ensured the date is accurate. The Plan terminated any intervention that was modified or changed (numerator /denominator) and ensured that was reflected in the appropriate tables. The change table was updated and reviewed. PIP Score: 87.5%	Addressed
The MCO should continue to negotiate a contract with pediatric providers in Atlantic County.	As of Q3, 2022, the Pediatric Provider deficiency for Atlantic County was cured. With the Q4 2022 submission and the application the new guidelines, the number of Pediatric Provider gaps increased significantly and at that time the Network Team had two fulltime Contract Negotiators. To positively impact paring down these deficiencies WellCare made the decision to hire an additional full-time Contract Negotiator who started in June. Additionally, a daily	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	touchpoint meeting was created to discuss potential targets that may fill the deficiencies. At these meetings which include the Contract Negotiators, Supervisors and Manager, barriers, leads, and progress are all discussed. WellCare continues to target Advocare as a group who has multiple Pediatric Providers in several counties. On 2/26/2023 received Advocare's W-9 to create a contract and begin the negotiation process which is currently ongoing. Presently, the group requested to be contacted in mid-August to schedule a meeting to discuss contracting. The Pediatric Primary Care (PCP) Provider network is monitored for compliance to ensure our members have access to care. Geo Access Reports are generated and reviewed quarterly. Mitigation Plan: Daily touchpoint meeting to review recruitment activities. Weekly DOBI/DMAHS Reporting Workgroup meeting with the market and our shared services partners with Network Integrity. Three dedicated Contract Negotiators to fill gaps. Requested access for Recruitment Team to have CAQH access so they can review the profiles of participating providers to potentially identify those with the Pediatric training and credentials to be added to their profile. Director of Network Management managing all activities around closing gaps.	
The MCO should continue to expand the MLTSS network to include at least two servicing providers in every County for Assisted Living and Medical Day Care.	Although WellCare continues to recruit to expand its MLTSS network with respect to Assisted Living there is a true deficiency outlined as follows: Hunterdon County- has only one facility, Independence Manor at Hunterdon. WellCare has a contract with Independence Manor at Hunterdon under PID#997140; NPI#1699984930. Salem County -The county has three facilities in the county. The health plan has attempted to recruit these facilities but they are not interested in becoming PAR. Friends Village is not a NJ Medicaid approved facility, Lindsay Place only accepts private pay, and Merion Gardens continues to decline a contract offer. We will continue to follow up periodically with the available facilities. We will continue to use providers in bordering counties to address needs and will offer transportation as indicated. As an immediate measure, WellCare has identified Senior Centers in the counties that we service and will use the list of centers as a resource to link members to services in their communities. Medical Day deficiencies in Sussex and Warren County are true deficiencies, there are no existing facilities in these counties. The health plan will continue to use providers in bordering counties to address member needs.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to focus on improving after-hours availability.	WellCare continues to focus on efforts to improve the After-Hours Availability results. On January 10, 2023, the Network Team was provided with the list of failed providers from the Semi II 2022 survey for outreach and education. The market contacted all failed providers. This was completed on January 22, 2023. After-Hours compliance showed a 13.3% increase from 77.7% in Semi II 2022 to 91.0% in Semi I 2023. The plan will continue to monitor after-hours appointment availability via the CAP monitoring plan.	Addressed
The MCO should ensure MLTSS providers submit an attestation as evidence for conducting criminal background checks as per Contract requirements.	In coordination with Provider Network Management, the Credentialing Department has implemented the following action steps to ensure all contracted providers conduct criminal background checks on all employees/providers with direct physical access to MLTSS Members: a. Updated enrollment document requirements to include proof or attestation from the Provider of completion of the Criminal History Record Information (CHRI) for those MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks. b. Credentialing/Recredentialing require the attestation from Providers that CHRI background checks are completed. 4/15/2023: Completed review and updated the Facility Application and Recredentialing Notification templates. c. On 4/17/23, an updated Facility Application was distributed including guidance detailing that without documentation of CHRI Background Checks files will be closed for non-compliance during the credentialing process. d. On 5/1/23 the Plan implemented Rejection at Cred/Recred for all files without CHRI background check documentation.	Addressed
The MCO should develop procedures and reports to monitor the training of new hire orientation along with retraining of current Member Services representatives when deficiencies are identified.	WellCare of NJ has resolved the deficiency related to procedures to monitor the training of new hire orientation as identified during the audit as follows: a. The Plan has existing policies and procedures in place to ensure that there is ongoing monitoring and documentation of training from new hire through tenured status. b. WellCare of NJ New Hire Training utilizes the Kirkpatrick Model as the standard assessment for training effectiveness. This includes Level 1 and Level 2 assessments. c. Level 1 assessments gauge the degree to which the participants find the training favorable, engaging, and relevant to their jobs. d. Level 2 assessments gauge the degree to which the participants have acquired the intended knowledge, skills, attitude, confidence, and commitment based on their participation in the training. e. The Plan provides ongoing training utilizing monthly team meeting agendas to review enhancements and changes to policies and procedures. f. Ongoing monitoring tis accomplished through quality assessments, call monitoring, and customer satisfaction surveys	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	to identify trends which may require retraining or refreshing agents.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, FC/WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	The following is the MCO's plan to address HEDIS quality-related goals that fall below the 50th percentile: Planned and Ongoing Interventions: a. Conduct quality focused provider education visits to individual providers/group practices to review coding and claims submission, existing Care Gaps and the importance of closure as well as deliver Provider Toolkits as an ongoing resource. These kits include information on all HEDIS measures, best practices guidelines as well as medical record documentation guidelines. b. These visits will also include the review of a medical record to identify any coding deficiencies then re-educating providers/practice managers. The team will leave a laminated coding sheet for ongoing reference. WellCare also provides a laminated coding sheet with the current codes for the billing staff to ensure claims are processed accurately and timely. WellCare's leadership and Quality team monitor visits monthly via QI metric reports. d. WellCare Preventive Service Outreach (PSO) program makes outbound calls to non-compliant members for various Medicaid measures notifying/educating them of their need for preventive services and assist with setting appointments. In addition, due to the continuous NJ Lead crisis within its water system, the Plan implemented an initiative for lead text messaging to assist with alerting parents/guardians on the importance of testing. Targeted in-person Pediatrics Providers visits which will focus on improving lead screening, well child visits and child and adolescent immunizations administration. NJ QI Performance Improvement Team (PIT) Work Group conducts weekly team meeting to review tracking of projects, rates, progress on measures, programs/initiatives and possible community outreach by our health educator for focused HEDIS measures. This meeting invitation is extended to cross-functional departments within the organization for collaboration on quality initiatives.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	The following is the MCO's plan to improve FIDE SNP Adult CAHP scores: Planned and ongoing interventions: a. WellCare of New Jersey has established a monitoring process (CAHPS Customer Service calls) in which recorded customer services calls are analyzed and training opportunities for Customer Service rep are identified. Goal is to improve the quality of care provided to members during inbound customer service calls. WellCare of New Jersey collects data and identifies opportunities of improvement by reviewing all Surveys including the Provider Satisfaction Survey results to help create actionable interventions. b. The Quality Practice Advisors in coordination with the Provider Relations team make visits to targeted groups/practitioners for education regarding use of the Provider Portal, specialists available in network, as well as Access and Availability standards. The Quality Provider toolkit is an easy-	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	to-understand education resource that they distribute that highlights HEDIS, CAHPS/HOS, Quality standards as well as coordination of care requirements in a nicely packaged, colorful folder for staff to reference. c. The visiting professionals reinforce phone numbers for Customer Service, Care Management and Community Connections with practitioners and staff to strengthen partnership for member care. d. The CAHPS workgroup to meets regularly and on an ad hoc basis to track the status of the Medicaid CAHPS work plan interventions and discuss progress and outcomes.	
FC/WCHP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: General Population: Identification, Outreach, Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	The plan continues to address the deficiencies in identification, outreach, preventive services, continuity of care and care coordination for the GP population through the following interventions: a. To improve initial IHS completion the plan has engaged Cotiviti and it's Eliza Member Engagement team on potential options to add rigor to the process by means of sending unable to contact (UTC) letters to all members identified as UTC by the vendor as well as adding 2 additional calls to their workflow when the call outcome is identified as a "hang up". IVR calls for this provider now have Caller ID to reflect the Fidelis Care name change. b. Continued collaboration with the Quality Department to identify members that are non-compliant with preventative services such as Dental, EPSDT Appointment and Flu/Pneumonia Vaccine. Educational materials are sent to all members engaged in CM. Outreach calls are made via Care Management, Quality Department and Liberty Dental to engage members and assist with appointment scheduling for preventative services. Tracking of Liberty Dental outreach calls to engage members for the purpose of completing their annual visits is monitored by the Dental Team monthly and discussed in the monthly collaboration calls with this vendor. Care Management continues to collaborate with Liberty Dental regarding members that need dental services with special needs. c. Care management and Quality have collaborated with the Pfizer Vaccine Adherence in Kids (VAKs) Program, to send monthly post cards based on the following: Well Visit (post card sent at 10 months old if there no Well Visit on file) and Missed Dose (CPT codes 90670 and 90671) for members who are 6 months old who had 1 dose of PCV13 but not the 2nd, members who are 8 months old with 1 or 2 dosed pf PCV13 but not the 3rd and members who are 17 months old who had 1,2,or 3 doses of PCV13 but not the 4th. d. Identified members that have no vaccination record on file receive outreach calls and reminder post cards to the most current mailing address e. The providers will continue to be notified of the gap in care via the Physician Score Card in addition to an office visit to retrieve medical records for the purpose of monitoring compliance.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
FC/WCHP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: DDD Population: Preventive Services, and all CM element specific deficiencies noted in the review.	The plan continues to address the deficiencies in preventive services for the DDD population through the following interventions: a. Care management continues to collaborate with the Quality Department to identify members who are non-compliant with preventative services such as Dental, EPSDT Appointments or Flu/Pneumonia Vaccine Appointments. Outreach calls and educational mailings are provided by Care Management, Quality Department and Liberty Dental to engage members and assist with appointment scheduling for preventative services. Tracking of Liberty Dental DDD outreach calls to engage members for the purpose of completing their annual visits is monitored by the Dental Team monthly and discussed in the monthly collaboration calls with this vendor. b. Care Management collaborates with Liberty Dental regarding members that need dental services with special needs. The Liberty Dental CM Team continues to manage members with complex dental needs to ensure that all needs are met by finding providers, scheduling appointments, and offering transportation. The plan's Care Management Team is responsible for identifying the members that are non-compliant with preventative services and offer appointment assistance and transportation as needed. Care Managers work in partnership with the DDD support staff such as Perform Care or the DDS social worker to discuss non-compliance with the member and collaborate on a plan of action. c. Quality and CM have formed a collaboration with the Pfizer Vaccine Adherence in Kids (VAKs) Program, to send monthly post cards based on the following: Well Visit (post card sent at 10 months old if there no Well Visit on file) and Missed Dose (CPT. codes 90670 and 90671) for members who are 6 months old who had 1 dose of PCV13 but not the 2nd, members who are 8 months old with 1 or 2 dosed pf PCV13 but not the 3rd and members who are 17 months old who had 1,2,or 3 doses of PCV13 but not the 4th. d. Identified members that have no vaccination record on file receive outreach calls and reminder post cards to their most current mailing address. Providers will continue to be notified of the gap in care via the Physician Score Card in addition to an office visit to retrieve medical records for the purpose of monitoring compliance.	Addressed
FC/WCHP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: DCP&P Population: Outreach, Preventive Services, and all CM element specific	The plan continues to address the deficiencies for outreach and preventive services for the DCP&P population through the following interventions: a. Care management continues to collaborate with the Quality Department to identify members who are non-compliant with preventative services such as Dental, EPSDT Appointments or Flu/Pneumonia Vaccine Appointments. Outreach calls and educational mailings are provided by Care Management,	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the review.	Quality Department and Liberty Dental to engage members and assist with appointment scheduling for preventative services. Tracking of Liberty Dental DDD outreach calls to engage members for the purpose of completing their annual visits is monitored by the Dental Team monthly and discussed in the monthly collaboration calls with this vendor. b. Care Management collaborates with Liberty Dental regarding members that need dental services with special needs. The Liberty Dental CM Team continues to manage members with complex dental needs to ensure that all needs are met by finding providers, scheduling appointments, and offering transportation. The plan's Care Management Team is responsible for identifying the members that are non-compliant with preventative services and offer appointment assistance and transportation as needed. Care Managers work in partnership with the DDD support staff such as Perform Care or the DDS social worker to discuss non-compliance with the member and collaborate on a plan of action. c. Quality and CM have formed a collaboration with the Pfizer Vaccine Adherence in Kids (VAKs) Program, to send monthly post cards based on the following: Well Visit (post card sent at 10 months old if there no Well Visit on file) and Missed Dose (CPT. codes 90670 and 90671) for members who are 6 months old who had 1 dose of PCV13 but not the 2nd, members who are 8 months old with 1 or 2 dosed pf PCV13 but not the 3rd and members who are 17 months old who had 1,2,or 3 doses of PCV13 but not the 4th. d. Identified members that have no vaccination record on file receive outreach calls and reminder post cards to their most current mailing address. Providers will continue to be notified of the gap in care via the Physician Score Card in addition to an office visit to retrieve medical records for the purpose of monitoring compliance.	
MLTSS - HCBS 2022 Care Management Review – Assessment Group D - WellCare should ensure that a Screening Community Service Assessment (SCS) is utilized to identify potential MLTSS needs and should be submitted by the 10th of the month following completion of the SCS.	1a. The WellCare LTSS Enrollment Specialist team completes all SCS tools for members who are referred to the MLTSS program. As of July 2022 the completion/submission of members with SCS is documented in member's EMR. 1b. A Monthly Case note report is run to monitor documentation of completion of SCS and submission. 2a. WellCare LTSS Enrollment Specialist team completes all SCS tools for members who are referred to the MLTSS program. As of July 2022 completion/submission of members with SCS is documented in member's EMR. 2b. The Supervisor of Clinical Care reconciles all monthly SCS tools completed, and submits a monthly report of members scoring between level 3-level 5 to DoAS on the 10th of each month for HCBS members and the 20th of each month for NF members per state guidance. 2c. Monthly Case note report is run to monitor documentation of completion of SCS and submission.	Addressed

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MLTSS - HCBS 2022 Care Management Review – Member Outreach Group C and D – 1. WellCare should ensure that the Care Manager initiates contact with the Member to establish a time for completion of an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program. 2. WellCare should ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification.	1a. WellCare has implemented a Care Management Onboarding Team that works solely with new members to the Plan and the MLTSS program. This team initiates contact with member upon enrollment and meets with member face-to- face to complete all initial documentation: MRR, POC, CES, BUP, Risk Assessment with Risk Agreement if needed, NJHC and PCA assessment as well as complete all necessary authorizations for services. 1b. WellCare has implemented a Resource Nurse Team to assist with welcoming new members to the MLTSS program upon enrollment as well as completing initial authorizations for services within the first 45 days of enrollment to include PPP. 1c. WellCare has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within 45 days of enrollment. 1d. Care Managers were provided training on the new member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 2a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 2b. Care Managers were provided training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 2c. WellCare LTSS Enrollment Specialist team completes all SCS tools for members being referred to the MLTSS program. As of July 2022 completion/submission of members SCS is documented in member's EMR.	Addressed
MLTSS - HCBS 2022 Care Management Review – Initial Plan of Care (Including Back-Up Plans) Group C - WellCare should ensure the Member has a completed, signed/verbally acknowledged Initial Plan of Care on file that is provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS	1a. WellCare has implemented a Care Management Onboarding Team that works solely with new members to WellCare and the MLTSS program. This team initiates contact with member upon enrollment and meets with member face to face to complete all of the initial documentation: MRR, POC, CES, BUP, Risk Assessment with Risk Agreement if needed, NJHC and PCA assessment as well as complete all necessary authorizations for services. 1b. WellCare has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within timeframes.	Addressed

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program. WellCare should ensure the Member is assessed for PCA services within 45 days of enrollment into MLTSS. WellCare should ensure that Members who have a change in condition or living arrangements have a PCA re-assessment. WellCare should ensure that Members who are identified as having a positive risk, have a signed/verbally acknowledged Risk Management Agreement with all of its components on file (not applicable for Members residing in CARS).	1c. Care Managers were provided training on the new member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 1d. WellCare has implemented a resource nurse team that assists with welcoming new members to the MLTSS program upon enrollment as well as completing initial authorizations for services within the first 45 days of enrollment to include PPP. 2a. WellCare has implemented a Care Management Onboarding Team that works solely with new members to WellCare and the MLTSS program. This team initiates contact with member upon enrollment and meets with members face-to-face to complete all of the initial documentation: MRR, POC, CES, BUP, Risk Assessment with Risk Agreement if needed, NJHC and PCA assessment as well as complete all necessary authorizations for services. 2b. WellCare has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within timeframes. 2c. WellCare has implemented a Resource Nurse team that assists with welcoming new members to the MLTSS program upon enrollment as well as completing initial authorizations for services within the first 45 days of enrollment to include PPP. 2d. Care Managers received training on the new member scorecard during their team meetings to reinforce timelines and completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 3a. WellCare Quality Assessment Review Team will monitor for change in condition NJHC's and ensure a PCA tool is updated accordingly. 3b. Monthly reconciliation of change in condition NJHC against plan of care and PCA tool updates. 4a. WellCare has implemented a Care Management Onboarding Team that works solely with new members to WellCare and the MLTSS program. This team initiates contact with member upon enrollment and meets with member face-to- face to complete all of the initial documentation: MRR, POC, CES, BUP, Risk Assessment with Risk Agreement if needed, NJHC and PCA assessment as well as complete all necessary authorizations for services. 4b. WellCare has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within timeframes. 4c. A weekly Risk Assessment report has been implemented to identify Risk assessments completed the week prior to ensure	

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	that those identified as having a risk also have a Risk Agreement on file. 4d. Care Managers were provided training on the new member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process.	
MLTSS - HCBS 2022 Care Management Review – Ongoing Care Management Group C - WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the Community. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a	1a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 1b. MLTSS Care Managers were re-educated during team meetings held in May 2023 on ongoing visit timeliness and completion of all documentation during face-to-face visits. 1c. Care Managers were provided training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 2a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 2b. MLTSS Care Managers were re-educated during team meetings held in May 2023 on ongoing visit timeliness and completion of all documentation during face-to-face visits. 2c. A Member Visit Report is distributed weekly to all MLTSS Managers/Supervisors that includes all documented/dated visits that are in the member's electronic record. The report will flag any missed or late visits according to member's living arrangement for review by Managers/Supervisors. This report will also be utilized to ensure Care Managers are updating member's documentation at each face-to-face visit to reflect accurate timelines. 2d. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 3a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 3b. Care Managers were re-educated during team meetings on counseling members regarding grievance and appeals processes	Addressed

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written notice of action that explains the Member's right to file an appeal.	and will document interaction in member's electronic medical record. 3c. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 4a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 4b. Care Managers were re-educated during team meetings on completion of Backup Plan in its entirety and completed timely and if not "completed" in system that Care Managers manually uploaded to member's electronic medical record. 4c. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 5a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 5b. Managers and Supervisors monitor the Daily Inpatient Census Report to identify potential change of conditions and refer to Care Manager for outreach/visit as needed. 5c. Care Managers received training on the new member scorecard during their team meetings to reinforce timelines and completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process.	
MLTSS - HCBS 2022 Care Management Review – Gaps in Care/Critical Incidents Group C - WellCare should ensure the Care Manager has documentation that they reviewed with the MLTSS Members receiving services, the process of immediately reporting gaps in service delivery (excludes Members residing in CARS).	1. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 2. Care Managers were re-educated during team meetings on counseling members during each face to face visit on reporting gaps in care and Care Managers are to document interaction in member's electronic record. 3. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure members receive services appropriately and are part of the care planning process. 4. Providers received training on the need to report gaps in services via EVV weekly reporting.	Addressed

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MLTSS - HCBS 2022 Care Management Review – Ongoing Care Management Group D - WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	1a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 1b. Care Managers were re-educated during team meetings on visit timelines for face-to-face visits to ensure members receive visits from Care Managers and there is no disruption in services, visits occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS and visit is documented in its entirely in the member's electronic record. 2a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 2b. MLTSS Care Managers were re-educated during team meetings held in May 2023 on ongoing visit timeliness and completion of all documentation during face-to-face visits. 2c. A Member Visit Report is distributed weekly to all MLTSS Managers/Supervisors that includes all documented/dated visits that are in the member's electronic record. The report will flag any missed or late visits according to member's living arrangement for review by Managers/Supervisors. This report will also be utilized to ensure Care Managers are updating member's documentation at each face to face visit to reflect accurate timelines. 2d. Care Managers received training on the member scorecard during their team meetings to reinforce timelines and completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 3a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 3b. Care Managers were re-educated during team meetings on counseling members regarding grievance and appeals processes and will document interaction in member's electronic medical record. 3c. Care Managers received training on the member scorecard during their team meetings to reinforce timelines and completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process.	Addressed

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MLTSS - HCBS 2022 Care Management Review – Telephonic Monitoring or Face-to-Face Visits Group E - WellCare should ensure the Member is offered the participant direction option. WellCare should ensure the Member has a cost neutrality analysis on file during the review period and include a calculation of the Member's Annual Cost Thresholds (ACT) represented as a numeric percentage.	1a. WellCare has implemented a Care Management Onboarding Team working solely with new members to the Plan and the MLTSS program. This team initiates contact with member upon enrollment and meets with member face to face to complete all of the initial documentation: MRR, POC, CES, BUP, Risk Assessment with Risk Agreement if needed, NJHC and PCA assessment as well as complete all necessary authorizations for services. 1b. WellCare has implemented a Resource Nurse team that assists with welcoming new members to the MLTSS program upon enrollment as well as completing initial authorizations for services within the first 45 days of enrollment to include PPP. 1c. WellCare has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within 45 days of enrollment. 1d. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 1e. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 2a. WellCare has a weekly visit report that is utilized by care managers to ensure all documentation is completed timely. This report has been adjusted to include monitoring of CEA completion. 2b. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within 45 days of enrollment. 2c. Care Managers received training on the member scorecard during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process.	Addressed
MLTSS - HCBS 2022 Care Management Review – Ongoing Care Management Group E - WellCare should ensure that Members receive timely telephonic visits to review placement and MLTSS Services during the review period. Ongoing telephonic visits should	1a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 1b. Care Managers were re-educated during team meetings on visit timelines for face to face visits to ensure members receive visits from Care Managers and there is no disruption in services, visits occur at least every 90 days for Members residing in the	Addressed

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occur at least every 90 days for Members residing in the Community, and at least every 180 days for Members in CARS. WellCare should ensure the Member's Plan of Care is reviewed and amended if applicable and signed/verbally acknowledged by the Member/Member Representative upon any significant change of the Member's needs or condition. WellCare should ensure Members with documentation of a disagreement with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal. WellCare should ensure that the Member's Back-up Plan is reviewed and revised if applicable, at least quarterly for Member's residing in the Community.	Community, and at least every 180 days for Members in CARS and visit is documented in its entirely in the member's electronic record. 1c. Care Managers received training on the member scorecards during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 2a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 2b. Care Managers were re-educated during team meetings on visit timelines for face to face visits to ensure members receive visits from Care Managers, there is no disruption in services, care managers are documenting updates to include dates in the plan of care in the member's electronic record and sending completed Plan of Care to members timely. 2c. Care Managers received training on the member scorecards during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 3a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 3b. Care Managers were re-educated during team meetings on counseling members regarding grievance and appeals processes and will document interaction in member's electronic medical record. 3c. Care Managers received training on the member scorecards during their team meetings to reinforce timelines, completing documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process. 4a. WellCare has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 4b. Care Managers were re-educated during team meetings on completion of Backup Plan in its entirety and completed timely and if not "completed" in system that Care Managers manually uploads to member's electronic medical record. 4c. Care Managers received training on the member scorecards during their team meetings to reinforce timelines, completing	

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	documentation in a timely manner, all to ensure member receives services appropriately and are part of the care planning process.	
MLTSS - HCBS 2022 Care Management Review – Performance Measure #9a Group C - WellCare should ensure the Member's Plan of Care is amended based on change of Member needs or condition.	1. WellCare Quality Assessment Review Team will monitor for change in condition NJHC's. 2. Monthly reconciliation of change in condition NJHC against the visits report that also monitors the plan of care completion.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - Facility and MCO Plan of Care - WCHP's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file	1. Specific case note type CFN (Care Facilitation Note) is being used to document receipt and review of the Nursing Facility Care Plan in the member's record. MLTSS Management is utilizing the Case Note Report to identify the CFN to ensure that a copy of the facility plan of care is in the member's record. 2. Record audits are performed monthly by WellCare's shared services Audit Team to ensure that member's electronic health record contains copies of any Facility Plans of Care on file. 3. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to the monthly record audits done by shared services, supervisors will do a focused review of 10% of the visits made each month to ensure that the Nursing Facility Plan of Care is in the member's record.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Initial Plan of Care and Ongoing Plans of Care - WCHP's MLTSS Care Managers should ensure that the Facility's Plan of Care is in the members file, that an Individualized Plan of Care is developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program.	1. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that there is an individualized Plan of Care (including obtaining Member's signature) developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program. 2. A mandatory in-service will be provided to all MLTSS Care Managers regarding individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review – MLTSS Initial Plan of Care and Ongoing Plans of Care - The Care manager should use a person-centered approach while using both formal and informal supports. Member's Plan of Care should have	1. WellCare MLTSS Care Managers were required to complete the annual PCT (Person-Centered Training) Training for the year 2022 to create person centered care plans inclusive of informal and formal supports available to the member. 2. New MLTSS Care Managers (employed for less than 3 months) are required to submit all plans of care for review at time of completion (prior to sending them to the Member and/or Member Representative) until their Manager/Supervisor is satisfied with plan of care quality. This review will include that the Care Manager used a person-centered approach regarding	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
developed goals that address the issues that are identified during the assessment and contain goals that met all criteria.	the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. 3. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the Care Manager used a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable.	
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Initial Plan of Care and Ongoing Plans of Care - The Care manager should use a person-centered approach while using both formal and informal supports.	1. WellCare MLTSS Care Managers were required to complete the annual PCT (Person-Centered Training) Training for the year 2022 to create person centered care plans regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. 2. New MLTSS Care Managers (employed for less than 3 months) are required to submit all plans of care for review at time of completion (prior to sending them to the Member and/or Member Representative) until their Manager/Supervisor is satisfied with plan of care quality. This review will also include that the Care Manager used a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. 3. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the Care Manager used a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review – MLTSS Initial Plan of Care and Ongoing Plans of Care - Member's Plan of Care should have developed goals that address the issues that are identified during the assessment and contain goals that met all criteria.	1. Mandatory in-service will be provided to all care managers on the importance of developing goals that address the issues that are identified during the assessment and care planning process. and that goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination processes. 2. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the Care Manager used a person-centered approach and developed goals with the member/member representative that address the issues that are identified during the assessment and Plan of Care process and goals are built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Initial Plan of Care and Ongoing Plans of Care - Member's Plan of Care should have developed goals that address the issues that are identified during the assessment and contain goals that met all criteria.	1. A mandatory in-service will be provided to all care managers on goal criteria (1- member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. 2. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the Plan of Care that was given to the member contained goals that met all the criteria below: -Be Member specific -Be measurable -Specify a plan of action/interventions to be used to meet the goals -Include a timeframe for the attainment of the desired outcome -Be reviewed at a minimum during each visit and progress shall be documented.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Initial Plan of Care and Ongoing Plans of Care - WellCare should ensure that documentation of the Member's agreement/disagreement with the Plan of Care statements were documented, and Member was identified for transfer to HCBS and was offered options.	1. A mandatory in-service will be provided to all care managers on proper documentation of the Member's agreement/disagreement with the POC statements on the Member's POC in the Member's electronic CM record. 2. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that WellCare's Plan of Care contains member's agreement/disagreement on the Plan of Care statements.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - Transition Planning - WellCare should ensure that Member was identified for transfer to HCBS and was offered options.	1. Mandatory in-service will be provided to all Care Managers regarding the importance of assessing facility members for transfer to the community and offering options regarding alternative living arrangements and documenting the Member/Member Representative's response in the member's electronic CM record. 2. WellCare's MLTSS Review Specialists will monitor NJ Choice Assessments for options counseling including alternative living arrangements during review prior to submission to OCCO.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - Transition Planning - The MLTSS Care Manager should confirm there is documentation of participation in at least one Facility IDT meeting annually.	1. WellCare's Internal Audit tool contains an audit element to ensure that there is documentation of an ICT note which indicates that Care Manager is participating in a minimum of one IDT meeting per year for Nursing Facility members. Record audits are performed monthly by WellCare's shared services Audit Team and results sent to MLTSS Managers/Supervisors. 2. Mandatory in-service will be provided to all Care Managers regarding the participation in at least one Facility IDT meeting annually and importance of documentation of same.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Documentation of CM participation in a minimum of one IDT meeting per year for NF members will be reviewed and discussed during 1:1 case conferences between Manager/Supervisor and Care Manager to ensure the there is documentation of same in member's electronic health record.	
MLTSS - NF/SCNF 2022 Care Management Review – Transition Planning - WellCare should ensure timely telephonic review of member placement and services and the MLTSS Care Managers is to discuss payment liability.	1. Member record audits are performed monthly by WellCare's shared services Audit Team to ensure that visit timeliness is in contractual compliance. Results will be tracked and used as a guide for reviewing areas of opportunity for improvement during 1:1 case conferences between Manager/Supervisor and Care Manager. 2. Mandatory in-service to be provided to all care managers reinforcing the following items: ---After member's initial visit, subsequent face-to-face visits need to be done at least every 180 days for Nursing Facility members and at least every ninety (90) calendar days for a Member residing in pediatric SCNF. ---Care manager to start to plan visits at least 10 days ahead of 180 day visit timeframe to help ensure compliance, to review member's placement and services and to document in the member's electronic record if the member/member representative is not available during that timeframe or visit needs to rescheduled.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - Transition Planning - WellCare should ensure timely telephonic review of member placement and services and the MLTSS Care Managers is to discuss payment liability.	1. All Care Managers will be re-educated on the need to explain and discuss payment liability with the Member/Member Representative and documentation of same in the member's electronic record. 2. An additional three Supervisor positions were added to the MLTSS Management team for needed oversight. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that there is documentation that the Care Manager discussed payment liability with the member/member representative.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - Reassessment of the POC and Critical Incident Reporting - The 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. WellCare's Internal Audit tool contains an audit element to ensure that the 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. Record audits are performed monthly by WellCare's shared services Audit Team and results sent to MLTSS Managers/Supervisors. 2. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the 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. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. 3. A mandatory in-service will be provided to all MLTSS Care Managers regarding Plans of Care (including Plan of Care was updated, reviewed, and signed by the Member and/or	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	representative and a copy was provided to the Member and/or representative	
MLTSS - NF/SCNF 2022 Care Management Review – Reassessment of the POC and Critical Incident Reporting - The Care Manager reviewed the Member's Rights and Responsibilities, educated the Member on how to file a grievance and/or an appeal and member and/or representative had training on how to report a critical incident.	1. Specific visit note templates were created for Care Manager within the member's electronic record as a reminder to review member rights and responsibilities and educate member on how to file grievance/appeal and Critical Incident training. 2. WellCare's Internal Audit Tool contains the element "care manager reviewed Member's Rights and Responsibilities". Record audits are performed monthly by WellCare's shared services Audit Team and results sent to MLTSS Managers/Supervisors for areas of opportunity to discuss with Care Manager. 3. A mandatory in-service will be provided to all Care Managers regarding the importance of reviewing Member Rights and Responsibilities with the Member/Member Representative, educated member on how to file grievance/appeal and Critical Incident training at least annually and documentation of same in the member's electronic record.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review – MLTSS Performance Measure PM8 - WCHP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS and should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary.	1. In addition to monthly shared services audits, supervisors conduct a focused review of 10% of the NF visits made each month to ensure that there is an individualized Plan of Care (including obtaining Member's signature) developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program. 2. A mandatory in-service was provided to all MLTSS Care Managers to reinforce the following regarding the individualized Plan of Care: a. Must be developed in collaboration with the Member b. The copy must be mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program c. Must include the member's signature.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Performance Measure PM9 - WCHP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS and should certify that the Member's Plan of Care is reviewed as needed and annually within 30 days of the Member's MLTSS anniversary	1. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that there is documentation that the Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary. Three additional Supervisor positions were added to the MLTSS Management team for needed oversight. 2. A mandatory in-service will be provided to all MLTSS Care Managers regarding proper documentation that the Member's Plan of Care was reviewed annually within 30 days of the member's anniversary and as necessary.	Addressed
MLTSS - NF/SCNF 2022 Care Management Review - MLTSS Performance	1. WellCare MLTSS Care Managers were required to complete the annual PCT (Person-Centered Training) Training for the year 2022 to create person centered care plans.	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Measure PM11 - The Care managers should use "person-centered principles" when developing their Plans of Care.	2. New MLTSS Care Managers (employed for less than 3 months) are required to submit all plans of care for review at time of completion (prior to sending them to the Member and/or Member Representative) until their Manager/Supervisor is satisfied with plan of care quality. This review will also include that the Care Manager used a person-centered approach regarding the Member assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. 3. In addition to monthly shared services audits, supervisors will do a focused review of 10% of the NF visits made each month to ensure that the Care Manager used a person-centered approach regarding the Member assessment and needs. Three additional positions were added to the MLTSS Management team for needed oversight.	
MLTSS - NF/SCNF 2022 Care Management Review – MLTSS Performance Measure PM16 - WCHP MLTSS Care managers should ensure that member training on identifying/reporting critical incidents is being completed.	1. Specific visit note templates were created for Care Manager for use in the member's electronic record as a reminder to review member rights and responsibilities, educate member on how to file grievance/appeal and Critical Incident training. 2. Record audits are performed monthly by WellCare's shared services Audit Team to ensure that there is documentation in the member's electronic health record that Care Manager educated member/member representative on Critical Incident training at least annually. 3. Documentation of above to be reviewed and discussed in 1:1 case conferences between Manager/Supervisor and Care Manager. 4. Mandatory in-service will be provided to all Care Managers regarding the importance of Critical Incident training at least annually and documentation of same in the member's electronic record.	Addressed

[1] **Addressed**: Managed care organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2024. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

HNJH Response to Previous EQR Recommendations

Table 59 displays HNJH's progress related to the *State of New Jersey DMAHS, Horizon New Jersey Health Annual External Quality Review Technical Report FINAL REPORT: April 2023,* as well as IPRO's assessment of HNJH's response.

Table 59: HNJH Response to Previous EQR Recommendations

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to expand the Dental/Specialty Dental network in Gloucester County. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers.	Horizon continues recruitment efforts to expand its dental network. The Senate bill 3000 (AKA CHOP bill) passed in late July 2022 that incorporates distance and time allows Horizon to cast a wider net with the surrounding counties. As of Q3, 2022, Gloucester County was at 100.00%, which meets the requirements and addresses the deficient coverage area for Dental/Dental Specialty providers.	Addressed
The MCO should focus on improving appointment availability for, adult PCPs, specialists, dental providers, and behavioral health providers, as well as improve after-hours availability.	Horizon is focused on educating dental providers, PCPs, specialists and behavioral health providers to improve appointment availability and after-hours access. Offices are still recovering from the COVID pandemic and rebuilding their staff and hours of operation. Horizon continues to establish multifaceted efforts to work with our network providers and bring them into compliance. 1) Horizon provided education to all providers (including dental providers, PCP, specialists and behavioral health providers) on appointment availability and the 24-hour access standards. Articles were posted in the provider newsletter in Q1 2023 regarding the 24-hour access and appointment available access standards. There were articles posted on Navinet and the provider newsletter in June Q2 2023 with specific information on the survey and the standards. Articles will also be posted in Q3 and Q4 of 2023 in the provider newsletter with the survey results for the network. 2) Providers that fail an audit receive education during the audit, such as written notification, and are requested to submit a corrective action plan. They are also subject to re-audit to ensure they are implementing the corrective action plan. In addition, providers that failed the re-audit received additional outreach and education from the Network Specialist team to assist in becoming compliant. This outreach was conducted via telephone. 3) New Provider Orientation was updated in Q1, 2023 to include specific talking points regarding the access standards. 4) Annual Survey review. We reviewed each question in the survey to ensure they are clear to providers. Definitions were also added that will assist the surveyor in obtaining accurate information. We received feedback from providers that fail one or more questions	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	on the appointment availability survey that they are in fact compliant, but when asked during the survey, the question was not clear. The review of the questions was completed to avoid provider misunderstanding going forward. 5) An email blast was sent to participating PCP Providers on 5/31/2023 to educate and remind them of the 24-hour Access standard and call out the requirement for an alternate phone number that must be given if an answering machine is used. This is the trend we see in our survey as the reason why most providers fail. Although providers have a valid answering machine, and call the member back within 45 minutes, they are still considered non-compliant because the answering machine did not also have an alternate phone number.	
The MCO should ensure every MLTSS provider submits an attestation as evidence for conducting criminal background checks as per Contract requirements.	The Ancillary/MLTSS Credentialing and Re-credentialing policy was revised on 10/14/22 to require a Criminal History Background Check Attestation to be completed by MLTSS providers per Contract requirements. Attestation is now being collected from MLTSS providers at the time of credentialing. A Criminal History Background Check Attestation Form was also created and incorporated into all MLTSS re-credentialing packets in November of 2022. For providers who did not complete the Criminal History Background Check Attestation at the time of re-credentialing, those attestations have been retroactively collected.	Addressed
The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	HNJH continues to monitor HEDIS measure performance on an ongoing basis in our efforts to improve health outcomes for our members. Several member and provider interventions were developed to help improve measure performance and close member care gaps. Barrier and impact analysis is completed annually to help guide future Interventions. HEDIS measure performance is reviewed during the HEDIS Workgroup with a report out to Quality Improvement Committee. In 2023, several initiatives are underway to improve performance for measures that fell below 50th percentile. The initiatives include: -Member education is provided via mailers and member newsletters on annual well visits, immunizations and preventive screenings. -Interactive Voice Recognition (IVR) campaigns are being utilized to educate members on needed screenings and to address barriers. This includes education on diabetes management, breast and cervical cancer screenings, asthma medication ratio and pediatric immunization. -Development of new Prenatal Care and Postpartum Care IVR call campaign that, includes information on TDAP and influenza vaccine (pending launch).	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	-Addition of Long-Acting Reversible Contraception (LARC) information and other forms of birth control on post-partum fliers that are sent weekly to members with live birth. -Continuation of member rewards program for prenatal and postpartum measures; Childhood Immunization and Lead Screening in Children measure; Diabetes A1C testing and Eye exam. -Live outreach calls for well child visits to parent/guardians with children with care gaps. -For providers participating in the Results and Recognition (R&R) program, a clinical quality improvement liaison is assigned to each provider site who shares provider gap reports on a regular basis. Live webinars are held quarterly educating providers on various measures. The R&R program provides several resources to the provider through the Quality Resource Center including billing tip sheets, HEDIS Guidelines, Provider Manual and recorded webinars. Additionally, recorded webinars are posted on the Quality Resource center and are available to all providers. -The Behavioral Health (BH) team continues to launch member and provider facing interventions focused on BH measures. Monthly Provider webinars continue in 2023 to educate providers on HEDIS Measures and best practices. The BH team has also launched member education via IVR and mailers for select measures. The BH HEDIS team is working to ensure that all HEDIS measures are included in member and provider newsletter.	
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	The Quality Management Team has been working very closely with Case Management, Member Experience, Network and Member Services teams to address all CAHPS measures with a targeted focus on measures not meeting the 50th percentile. Providers are educated through multiple channels on CAHPS measures, with a focus on 24 hour access to care in 2023. Access to care is being highlighted in the new provider orientation, monthly webinars and the provider newsletters. In addition, each provider newsletter (3 per year) will include CAHPS related articles. March 2023 included a CAHPS Overview, Fast Facts on Patient Experience with links to the Playbook for Patient Engagement, a CAHPS tip sheet and a discussion checklist. Additional articles included Ensuring Patients have Access to Care, which reviewed 24 hour coverage and appointment availability. The June issue included Behavioral Health Patient resources, Care Coordination for Patient Centered Care, 24 hour Access and Appointment Availability Standards, and Member Rights and Responsibilities. The Sept Issue will contain an article on the importance of Annual Wellness Visit for both Adult and Pediatric populations. A CAHPS webinar series will be conducted for providers in 2023. The webinars are offered on a quarterly basis to approximately 985	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	PCPs and specialists active in the Results and Recognition (R&R) Program and all Value Based providers, which cover approximately 305,600 members. Monthly webinars beginning in Q1 and running through Q4 of 2023 are being conducted with a focus on key CAHPS Topics. The CAHPS webinars are also being recorded and will be placed on the provider resource center for providers to view on demand. In addition to webinars, the CAHPS coaching program will continue in 2023. A mock CAHPS survey (Proxy) was sent out on June 12, 2023 and the report will be delivered in October 2023.The survey includes Medicaid patients from 18 key partner groups. Scorecards will be provided which will be used in the development of coaching plans. In Q4 2023 and Q1 2024, the CAHPS Coach along with the Value Based team will review the 2023 Proxy results vs 2022 Proxy results with Key Alliance and Value Based provider partners to discuss opportunities for improvement. Member education is provided through multiple channels. The QM launched Healthy Lifestyle Rewards Program. This program serves to educate members with a diabetes diagnosis about the importance of diabetes management and incentivize respective members to complete their diabetes A1C and diabetic retinal eye exam. Quarterly member newsletters included education for members. Issue 1: articles included 6 tips to get the most from your plan (assistance with scheduling appointments, accessing benefits with online tools), Scheduling Annual Wellness Visit, Reminder to get the flu vaccine, and What to do After an ER visit. Issue 2: Articles included Community Support Available and Getting the Right Care at the Right Time. Issue 3 is under development but will include topics on the importance of immunizations and communicating with your doctor. Lastly, the Member Service teams are completing additional training in 2023. Education is being provided to Member Service Agents on call handling requirements for calls related to members receiving bills from providers to help reduce repeat calls, mitigate complaints/escalations, and improve member satisfaction. Member Service Agents are also receiving soft skills training, which is focused on skills that are aimed at positively impacting member satisfaction including active listening, empathy, de-escalation, and communication. The CAHPS interventions are tracked and updated on a weekly basis to ensure interventions are on track and new interventions are developed based on identified opportunities and CAHPS scores that are below the 50th percentile.	
HNJH should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following	Horizon continues to monitor the following areas to address CM specific deficiencies noted in the review. Ongoing actions include the following:	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
areas: General Population: Identification, Outreach, Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	– In April 2023, all Care Management staff completed a Preventative Health Training; this will occur annually. – Continuous review of trigger reports to enhance our ability to identify members for care management services. This update was completed 3/15/23. – Continuous review of tracking mechanisms that monitor compliance; modifications were completed as indicated. This update was completed 7/26/23. – Ongoing review and modification to current work processes based on any trends that might be identified via tracking mechanisms. Updates are completed annually at a minimum, or more often as warranted. – Preventative care mailers are distributed to members throughout the year.	
HNJH should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: DDD Population: Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	Horizon continues to monitor the following areas to address CM specific deficiencies noted in the review. Ongoing actions include the following: – In April 2023, all Care Management staff completed a Preventative Health Training which will occur annually. – Ongoing review and modification to current work processes based on any trends that might be identified via tracking mechanisms. Updates are completed annually at a minimum, or more often as warranted. – Preventative care mailers are distributed to members throughout the year.	Addressed
HNJH should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: DCP&P Population: Preventive Services, and all CM element specific deficiencies noted in the review.	Horizon continues to monitor the following areas to address CM specific deficiencies noted in the review. Ongoing actions include the following: – In April 2023, all Care Management staff completed Preventative Health Training, which will occur annually. – Ongoing review and modification to current work process based on any trends that might be identified via tracking mechanisms. Updates are completed annually at a minimum, or more often as warranted. – Preventative care mailers are distributed to members throughout the year.	Addressed
HNJH should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%.	HNJH submitted its MLTSS – NF/SCNF 2022 CM Audit Corrective Action Plan (CAP) on 1/26/23. Horizon continues to monitor the following areas identified as opportunities for improvement (scoring below 86%). Ensuring MLTSS Care Managers: – Confirm that there is documentation of participation in at least one facility IDT meeting annually; – Retain a copy of the facility's Plan of Care in the MLTSS member's file; – Discuss payment liability with MLTSS members;	Remains an opportunity for improvement

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	– Develop Individualized Plans of Care in collaboration with MLTSS members and mail a copy to members within 45 – calendar days of MLTSS enrollment notification; and – Review MLTSS members' Plans of Care and revise them, if applicable, for any significant changes (PM#9a). In an effort to address those areas of opportunity, HNJH updated and reissued numerous MLTSS Care Manager Operational Workflows; re-educated Care Management staff at team meetings; communicated with facility-based providers about the importance of collaborating with assigned care management staff related to member care planning issues/meetings; held multiple care management MLTSS CM NF/SCNF Workgroup meetings specifically for staff designated to serve facility-based members; and conducted an internal 'mock NF/SCNF chart audit' to review internal case files for proper documentation. Additionally, the State requested a quarterly follow-up for this CAP on 6/12/23. In its response, HNJH described the monitoring efforts in place to improve compliance, which included: 1. Operational Workflows are reviewed at monthly MLTSS Care Management Supervisors meetings including procedures for timely development of initial Service Plans of Care and Significant Change in Condition guidance, as well as ongoing monitoring efforts including MLTSS Dashboard Compliance Reporting. Periodic NF/SCNF Care Management Workgroups are held with staff (February and June 2023) and those opportunities continue to be used to discuss continual quality improvement opportunities and ways to enhance reporting review processes to increase compliance. 2. Every month the Horizon CM Quality Improvement team runs and distributes the findings from the NF IDT Monitoring Report to the MLTSS Senior Manager for review. Findings are analyzed and trends of Care Managers being included in facility IDTs are improving. However, continued efforts are being sought to encourage communication and understanding by nursing facility providers, of their recognizing the importance of ongoing care coordination efforts for facility-based MLTSS members. 3. Secured the two specific NF/SCNF chart numbers cited by IPRO as not including an updated plan of care after the member experienced a significant change in condition. Those two prepared charts were reviewed by MLTSS management and then forwarded to the applicable MLTSS CM Supervisor so they could provide one on one re-education/training with the assigned MLTSS Care Manager for each case.	

[1] **Addressed**: Managed care organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2024. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

UHCCP Response to Previous EQR Recommendations

Table 60 displays UHCCP's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Community Plan of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2023,* as well as IPRO's assessment of UHCCP's response.

Table 60: UHCCP Response to Previous EQR Recommendations

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address the PIP validation elements that were determined to be not met or partially met.	The MCO scored 100% on the August 2022 submissions of all PIPs with the exception of the MLTSS Behavioral Health FUH PIP. Based on IPRO recommendations on the August 2022 submission of the FUH PIP, the MCO ensured that all of the interventions were correctly numbered and not renamed. The MCO also ensured that the correct PIP template was used for the August 2023 submission. Furthermore, the MCO corrected and updated all intervention tracking measures results in Table 1b and added footnotes. The MCO received positive feedback on the April 2023 submission. Corrected and updated FUH PIP was submitted to IPRO in August 2023.	Addressed
The MCO should continue to expand the Dental/Specialty Dental network in Atlantic, Cumberland and Morris Counties. The MCO should continue to negotiate contracts to meet deficient coverage areas for Dental/Specialty Dental providers.	As of July 2023, the dental/specialty dental network in Atlantic, Cumberland and Morris counties are not deficient in any GeoAccess network coverage areas.	Addressed
The MCO should continue to address hospital deficiencies in Atlantic and Cumberland Counties.	UHC is currently contracted with all hospitals in Atlantic & Cumberland Counties. – Salem Medical Center part of Inspira Health System (Cumberland County) contracted 9/1/2022 – Atlanticare (Atlantic County) – Shore Medical Center (Atlantic County)	Addressed
The MCO should continue to expand the MLTSS network to include at least two providers in every County for Medical Day Care.	There are 3 counties that currently do not meet the two per county provider requirement for Medical Day Care for the MLTSS network with one provider in those counties. They are Cape May, Hunterdon, and Sussex. For Cape May, the only other option was Caring Inc., which was terminated due to failure to recredential and is not currently registered for a Medicaid ID as of 8/25/2023. For Hunterdon and Sussex, after checking the State website, other MCO provider directories, and competitive date, there are no other providers to contract with within these counties to meet the 2 per county requirement.	Addressed
The MCO should focus on improving appointment availability for OB/GYN, High Volume Specialist, and Behavioral Health	1. UHC Quarterly Appointment Availability reporting demonstrates that there are providers who are available for appointment scheduling within DMAHS requirement timeframes. UHC Member Services team can help to schedule an appointment on behalf of	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
providers, as well as improve after-hours availability.	the member, with the provider for specialty being requested, within those timeframes. 2. UHC will work with providers who are identified as deficient in after-hours access. These providers will continue to receive up to 3 letters after each of up to 3 survey calls from third party call vendor, Dial America, which educates the provider on the appointment availability standards for their specialty set forth by DMAHS.	
Quality Program Evaluation looks at performance by age band. Many of the measures are relevant to the Elderly and Disabled population. However, in their analyses of performance, the plan does not focus on these measures with regard to the Elderly and Disabled population. The plan should develop an analysis plan that focuses on assessment of quality measures for the Elderly and Disabled and MLTSS populations.	UHCCP NJ developed reporting that focuses on the Elderly, Disabled and MLTSS populations relative to preventive services, chronic disease management and cancer screenings. This reporting is shared with key stakeholders including Care Management, MLTSS Team, and other cross functional departments with the goal of closing care opportunities for these populations.	Addressed
The MCO should initiate a system for monitoring providers for compliance with state and federal laws and regulations concerning family planning services for minors.	UHCCP NJ designed and implemented a process whereby providers are monitored for compliance with state and federal laws and regulations related to family planning services for minors. Providers responses are tracked, regularly reviewed with the plan's medical leadership and action taken if required.	Addressed
Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	UHCCP NJ reviews Measurement Year HEDIS results and performs a barrier analysis that includes feedback from members/parents and providers. Interventions are developed and implemented with the goal of improving measure rates. Member and provider outreaches are reviewed, as well as the effectiveness of existing programs and resources. Updates and expansion of programs occur as needed. Rates for all HEDIS measures are reviewed monthly and include a YOY comparison. Communication of ongoing measure performance occurs at a variety of committee meetings attended by key stakeholders and plan leadership.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores	A CAHPS workplan was developed for 2023 and submitted to DMAHS. The Workplan included interventions for improving the following survey rates that did not meet the 50th percentile: Health Plan, Health Care, Getting Needed care, Getting Care	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
that perform below the 50th percentile.	Quickly, Customer Service, Doctor Communication and Specialists. It included intervention activities that focused both on our members and our providers. This Workplan is monitored on a regular basis and reported quarterly to the Quality Management Committee (QMC). The MCO has a CAHPS Taskforce that also monitors the CAHPS Workplan. Individual subtask forces are being developed to focus on the top complaints that might affect our rates.	
UHCCP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: General Population: Identification, Outreach, Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	United Healthcare Community Plan (UHCCP) has a specific Initial Health Screen (IHS) referral process that allows identification of members that completed an IHS with a score of 5 or more needing a Comprehensive Needs Assessment. These members are outreached by a registered nurse within 30 days of the completed IHS to determine care management needs. To ensure continuity of care, UHCCPNJ continues educating newly enrolled and existing members on the importance of preventative services at each outreach. Upon enrollment to case management UHCCPNJ provides age-appropriate educational materials in writing via preventative health mailings to include lead, dental, immunizations and overall health screenings for all new enrollees. NJIIS immunization and lead reports for all members enrolled in care management are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during routine monthly audits and random case reviews are conducted to ensure educational materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training. Tracking mechanisms are in place to ensure compliance. Upon enrollment in case management the case manager creates a member centric Plan of Care in collaboration with member/caregiver, provider(s) as well as internal and external partners to coordinate services and provide linkage to community support services. The care manager continues collaboration with the member and/or caregiver, as well as maintains communication with providers and state partners to monitor plan of care goals for completion/obstacles and gaps in care. Various data sources are used to monitor for hospitalizations. The care manager works collaboratively with the inpatient and discharge care management teams to ensure adequate and appropriate discharge planning occurs. Multi-disciplinary rounds are conducted weekly to present and discuss complex cases.	Remains an opportunity for improvement
UHCCP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas:	To ensure continuity of care, UHCCPNJ continues educating newly enrolled and existing DDD members on the importance of preventative services at each outreach. Upon enrollment to DDD case management UHCCPNJ provides age-appropriate educational materials in writing via preventative health mailings to include	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
DDD Population: Preventive Services, Continuity of Care, and all CM element specific deficiencies noted in the review.	lead, dental, immunizations and overall health screenings for all new enrollees. NJIIS immunization and lead reports for all members enrolled in care management are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during routine monthly audits and random case reviews are conducted to ensure educational materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training. Tracking mechanisms are in place to ensure compliance. Upon enrollment in DDD case management the case manager creates a member centric Plan of Care in collaboration with member/caregiver, provider(s) as well as DDD state and community partners to coordinate services and provide linkage to other support services. The care manager continues collaboration with the member and/or caregiver, as well as maintains communication with providers and state partners to monitor plan of care goals for completion/obstacles and gaps in care (they may include Community Access Unlimited and others). Various data sources are used to monitor for hospitalizations. The care manager works collaboratively with the inpatient and discharge care management teams to ensure adequate and appropriate discharge planning occurs. Multi-disciplinary rounds are conducted weekly to present and discuss complex cases.	
UHCCP should address the deficiencies noted in the Core Medicaid -2022 CM Review in the following areas: DCP&P Population: Preventive Services, and all CM element specific deficiencies noted in the review.	To ensure continuity of care, UHCCPNJ continues educating newly enrolled and existing DCP&P members on the importance of preventative services at each outreach. Upon enrollment to case management UHCCPNJ provides age-appropriate educational materials in writing via preventative health mailings to include lead, dental, immunizations and overall health screenings for all new enrollees. NJIIS immunization and lead reports for all members enrolled in care management are provided to the assigned clinicians with a copy of the current immunization recommendation schedule for review. Focused review of preventative measures during routine monthly audits and random case reviews are conducted to ensure educational materials were mailed and addressed. Preventative measures training continues for all current and newly hired staff as well as annual health quality measures training. Tracking mechanisms are in place to ensure compliance. Upon enrollment in DCP&P case management the case manager creates a member centric Plan of Care in collaboration with member/caregiver, provider(s) as well as DCP&P state partners to coordinate services and provide linkage to community support services. The care manager continues collaboration with the member and/or caregiver, as well as maintains communication with providers and state partners to monitor plan of care goals for	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	completion/obstacles and gaps in care (this may include Child Health RNs, or various county DCP&P office staff). Various data sources are used to monitor for hospitalizations. The care manager works collaboratively with the inpatient and discharge care management teams to ensure adequate and appropriate discharge planning occurs. Multi-disciplinary rounds are conducted weekly to present and discuss complex cases.	
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Assessment	Assessment: SCS completed on members who request MLTSS in the community setting and stored in the members' electronic record. The names and scores for those that scored a 3, 4, or 5 were entered on the state's SCS temporary Waiver Spreadsheet. Group D- Remediation- the SCS Temporary Waiver Spreadsheet was submitted timely one or before the 10th of the following month. The Care Management Team continues to complete the SCS tool for all members requesting MLTSS. The Managers place the names of all Members who scored a 3, 4, or 5 on the state's Temporary Waivers for MLTSS spreadsheet. The report is submitted by the 10th of every month. Tracked and reviewed by management team prior to submission. Compliance sends reminder emails of due date one week prior to the 10th. Compliance tracks and monitors all submissions to the state.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Member Outreach	Member Outreach: Group C Remediation UHC will ensure that the Care Manager contacts the Member within five (5) business days of MLTSS enrollment to schedule a telephonic visit to develop the Member's Plan of Care. Member Welcome Call – the assignment of the new members will be assigned to the CM teams one (1) week. prior to the first of the month to allow the CM the ability to contact the member timely after the first day of the month. The end-to-end process for HCBS was revised to include the documentation of the Welcome Call and date of the visit to complete the POC and other required documentation. CMs were trained on the process and completed the mandatory post-training quiz. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload.	Remains an opportunity for improvement
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Telephonic Monitoring (formerly Face-to-Face) Visits	Group C Remediation: United Healthcare will make certain and confirm that the Member (or Member's Representative) are present for, and included in, all telephonic meetings or face-to-face visits with the Care Manager. United Healthcare should ensure Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion. The Plan will safeguard a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold be documented as a numeric percentage. POC was revised to include a place for the Member Representative to sign if the Member is cognitively impaired or otherwise not able to participate in the POC	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	development. The POC has a place to document who was present during the call or visit. 1. SCS Template job aid was revised to include documentation regarding PPP option. 2. The POC was revised to include documentation regarding the option of PPP to the member. 3. The documentation of PPP is included in IPOC which was re-implemented with the return to field. 1. Revised the POC to include a place for CEA documentation. 2. The POC was later revised to make the documentation mandatory within the POC as opposed to other locations. 1. Managers have the CMs document the CEA in their weekly tracker. 2. Managers review the weekly tracker with the CM during their weekly 1:1 meeting. Group D Remediation: United Healthcare will track and confirm that Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion. 1. IPOC was re-implemented upon return to field instructions by the state. 2. Options Counseling training was completed for all CMs. 3. 100% SCS tools were moved to the Assessment team for completion as the CMs returned to field. 4. The Assessment team was trained on the SCS Template job aid which included the type of options counseling completed for the member. 1. SCS Template job aid was revised to include documentation regarding PPP option. 2. The POC was revised to include documentation regarding the option of PPP to the member. 3. The documentation of PPP is included in IPOC which was re-implemented with the return to field. 1. Revised the POC to include a place for CEA documentation. 2. The POC was later revised to make the documentation mandatory within the POC as opposed to other locations. 1. Managers have the CMs document the CEA in their weekly tracker. 2. Managers review the weekly tracker with the CM during their weekly 1:1 meeting. Group E Remediation: United Healthcare will track and confirm Options Counseling is provided to all MLTSS Members, and the MLTSS Care Manager should discuss and offer Participant Direction as applicable during Options Counseling. The Plan should ensure that a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold should be documented as a numeric percentage. 1. SCS Template job aid was revised to include documentation regarding PPP option. 2. The POC was revised to include documentation regarding the option of PPP to the member. 3. The documentation of PPP is included in IPOC which was re-implemented with the return to field. 1. Revised the POC to include a place for CEA documentation. 2. The POC was later revised to make the documentation mandatory within the POC as opposed to other locations. 1. Managers have the CMs document the CEA in their weekly tracker. 2. Managers	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	review the weekly tracker with the CM during their weekly 1:1 meeting.	
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Initial POC and Back-up Plan	Initial POC and Back-up Plan: Group C Remediation: United Healthcare will ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member representative, and a copy of the Plan of Care will be provided to the Member within 45 days of enrollment in the MLTSS program. During the training, timeframes for completion of the POC were reinforced additional training completed in April and June 2022 to reinforce SMART goal and intervention development. 1. Completed a staffing analysis which showed a deficit in staffing levels. Human Resources began an intense campaign to hire CMs to bring staffing levels to contractual requirements. 2. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the POC within 45 days and the importance of having the member complete the documentation of understanding of the POC. 3. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. POC was revised to include a statement that the POC will be mailed to the PCP and member signed agreement. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the Options Counseling, PCA tool, and POC within 45 days. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. Training for member-centric documentation to include SMART goals with the participation of the Member was completed. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. Group D Remediation: United Healthcare will confirm that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member Representative, and a copy of the Plan of Care will be provided to the Member within 45 days of MLTSS enrollment. This report is monitored daily by the managers and	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	weekly by the executive team. The POC was completely revised, trained, and implemented during Q1 2022. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. 1. Completed a staffing analysis which showed a deficit in staffing levels. Human Resources began an intense campaign to hire CMs to bring staffing levels to contractual requirements. 2. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the POC within 45 days and the importance of having the member complete the documentation of understanding of the POC. 3. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the Options Counseling, PCA tool, and POC within 45 days. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. Training for member-centric documentation to include SMART goals with the participation of the Member was completed. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. Group E Remediation: United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. A Combo report has been developed to monitor the enrollment date and the date the Plan of Care is due to ensure the POC is completed by day 45. This report is monitored daily by the managers and weekly by the executive team. The POC was completely revised, trained, and implemented during Q1 2022. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. During the training, timeframes for completion of the POC were reinforced additional training completed in April and June 2022 to reinforce SMART goal and intervention development. Audits are completed quarterly to review the POC to ensure person-centered	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	approach. Reporting for adherence to required timeframes is run daily and provided to the management team. Risk Assessment and Risk Management Agreement are completed initially, annually, and change in condition. All required documentation of the Back-Up Plan was put in the revised Plan of Care that was rolled-out in March 2022. Member Rights and Responsibilities: Includes the process for grievance/appeals and how to report a Critical Incident. The Member Rights and Responsibilities is signed by the member initially and annually. Additional documentation is in the Plan of Care. Training for member-centric documentation to include SMART goals with the participation of the Member was completed. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy.	
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Ongoing Care Management	Ongoing Care Management Group C Remediation: The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. A Combo report has been developed to monitor the enrollment date and the date the Plan of Care is due to ensure the POC is completed by day 45. This report is monitored daily by the managers and weekly by the executive team. The POC was completely revised, trained, and implemented during Q1 2022. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. During the training, timeframes for completion of the POC were reinforced additional training completed in April and June 2022 to reinforce SMART goal and intervention development. Audits are completed quarterly to review the POC to ensure person-centered approach. Reporting	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	for adherence to required timeframes is run daily and provided to the management team. Risk Assessment and Risk Management Agreement are completed initially, annually, and change in condition. All required documentation of the Back-Up Plan was put in the revised Plan of Care that was rolled-out in March 2022. Member Rights and Responsibilities: Includes the process for grievance/appeals and how to report a Critical Incident. The Member Rights and Responsibilities is signed by the member initially and annually. Additional documentation is in the Plan of Care. Training for member-centric documentation to include SMART goals with the participation of the Member was completed. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. There is a designated team that reviews discharges from facilities via the Blended Census Reporting Tool to notify CM of recent Discharge from an institution. CM calls the member within 10 days of discharge to confirm services have resumed and no other services are needed. Will schedule a face-to-face visit for any change in condition due to the hospitalization. Group D Remediation: The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. The Plan of Care was revised to capture the update the changes made to the Member's	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	POC and is reviewed, updated, and signed by the CM at all touch points. Documentation at the end of the POC provides statement the member participated in the development of the POC, this includes updated training provisions around change in condition Plan of Care development and the secure of the amended, reviewed and verbally acknowledged POC by the member and/or authorized representative. Member will receive a copy of the POC. Group E Remediation: The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. The Plan of Care was revised to capture the update the changes made to the Member's POC and is reviewed, updated, and signed by the CM at all touch points. Documentation at the end of the POC provides statement the member participated in the development of the POC, this includes updated training provisions around change in condition Plan of Care development and the secure of the amended, reviewed and verbally acknowledged POC by the member and/or authorized representative. Member will receive a copy of the POC. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. Members displaying disagreement with the with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) will be counseled by the Care Manager related to a written notice of action that will explain the member's rights to file an appeal. United Healthcare will certify that the Care Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting.	
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2022 CM Review for elements that scored below 86%: Gaps In Care- Critical Incident	Gaps In Care- Critical Incident Group C Remediation: Care Managers identifying a gap in care for members receiving MLTSS and not residing in community alternative settings will follow the documented escalation process. Plan of Care training to reinforce obtaining the member's acknowledgement. Managers provided reminders to their CM teams during huddles. Reinforcement of the Gap in Care job aid which includes documentation in an activity the notification of the gap in care, the reason for the gap in care and the steps taken to resolve the gap in care. Plan of Care contains an agreement statement where the member acknowledges they received the	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Member Rights and Responsibilities and is aware. Members displaying disagreement with the with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) will be counseled by the Care Manager related to a written notice of action that will explain the member's rights to file an appeal. United Healthcare will certify that the Care Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting. Critical Incident training is completed during on boarding and then annually with a required post-test. Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve. Group D Remediation: Care Managers identifying a gap in care for members receiving MLTSS and not residing in community alternative settings will follow the documented escalation process. Plan of Care training to reinforce obtaining the member's acknowledgement. Managers provided reminders to their CM teams during huddles. Reinforcement of the Gap in Care job aid which includes documentation in an activity the notification of the gap in care, the reason for the gap in care and the steps taken to resolve the gap in care. Plan of Care contains an agreement statement where the member acknowledges they received the Member Rights and Responsibilities and is aware. Members displaying disagreement with the with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) will be counseled by the Care Manager related to a written notice of action that will explain the member's rights to file an appeal. United Healthcare will certify that the Care Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting. Critical Incident training is completed during on boarding and then annually with a required post-test. Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve.	
UHCCP should address all opportunities for improvement in MLTSS performance measures	Opportunities for Improvement for Performance Measures: Group D: PM #9a: The Plan of Care report are reviewed by the managers on a weekly basis. Clinical audits were initiated to ensure POC was completed for each member. The clinical audit tool revised to ensure congruency between POC and the authorized services. The Plan of Care was reformatted to ensure documentation for all formal services. Reinforced the POC should be completed on all members initially, with every touchpoint and change in condition. Reinforcement of Plan of Care acknowledgement including signature, date and/or authorized representative was conducted with each Case Manager as well as in the formal training. Member's needs or change in condition is addressed in updated Plan of Care changes aligning with member's current or changing needs.	Remains an opportunity for improvement

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Group C/Group D: PM #10: Revise the clinical audit tool to confirm the congruency of the formal services and the authorizations. Reinforced the POC should be completed on all members initially, with every touchpoint and change in condition. Reinforcement of Plan of Care acknowledgement including signature, date and/or authorized representative was conducted with each Case Manager as well as in the formal training. Member's needs or change in condition is addressed in updated Plan of Care changes aligning with member's current or changing needs. Group C/Group D/Group E: PM #11: Manager reviewed with staff on person-centered care needs for the NF member based on focus audit of NF POC's. 1. Plan of care training was provided to the staff 2. Plan of care is being revised to ensure principles and language are person-centered. Resource Hours focused on Patient-Centered care occurs quarterly and/or as needed. Training for member-centric documentation to include SMART goals with the participation of the Member was completed. Group C/Group D/Group E PM #12: Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan ensuring the date is reviewed and captured. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. The Clinical Audit was revised to include development of the back-up plan. Group C/Group E: PM #16: Critical Incident training is completed during on boarding and then annually with a required post-test. Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve. Managerial review of NJ Choice reporting tool to review completion statuses of the NJ Choice. Plan of Care contains an agreement statement where the member acknowledges they received the Member Rights and Responsibilities and is aware.	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Copies of any Facility Plans of Care on file	The MLTSS management team continues to monitor POC completion report weekly and meet with the individual CMs monthly to ensure timely completion with the initial POC within 45 days and ensuring members have a copy. Re-education and assistance with visit prioritization are provided to CM staff by manager as needed during 1:1 meeting. Annual training for MLTSS CM NF face to face visit process was completed in July 2023. The MLTSS chart audit has been revised to include confirmation that the initial POC was mailed within the 45-day timeframe.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	All Case Managers are trained on internal documentation system to ensure appropriate POC mapping	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Individualized Plan of Care was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program	Annual training for MLTSS CM NF face to face visit process will be completed July 2023 in the care manager weekly huddles. This training will include NF IDT requirements for chart documentation to capture annual IDT compliance. Manager training occurred on 7/11/2023 and included the process for tracking annual NF IDT using weekly activity reporting. All Case Managers are trained on internal documentation system to ensure appropriate POC mapping.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Managers used a person-centered approach	Person-Centric training is part of the Case Management process and was reviewed during orientation and ongoing training activities. SMART goal language is part of the audit tool used by the Managers to ensure goals are measurable, specific, include attainable and realistic interventions to meet goal, with established timeframe for attainment for desired outcomes. Revised POC was rolled out and intensive training provided on person-centric language. POCs are audited by Managers for both formal and Informal supports documentation.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager arranged Plan of Care services using both formal and informal supports	Revised POC was rolled out and intensive training provided on person-centric language. POCs are audited by Managers for both formal and Informal supports documentation. Assessment Needs Summary text area was added for overall Formal and Informal needs.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process	Revised POC was implemented. Intensive training provided on person-centric language. SMART Goal person-centered training was provided with POC roll-outs. Ongoing education and coaching provided individually and informally within other presentations. All POC are audited with feedback provided to the CM and manager.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Plan of Care that was given to the member contained goals that met all the criteria	Revised POC was implemented. Intensive training provided on person-centric language. SMART Goal person-centered training was provided with POC roll-outs. Ongoing education and coaching provided individually and informally within other presentations. All POC are audited with feedback provided to the CM and manager.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Documentation of the Member's agreement/disagreement with the POC statements were documented	POC was revised to include a place for cognitive impairment documentation. POC was revised to include documentation for POA/Caregiver to sign POC. POC will be revised to add the reminder statement.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Updated Plan of Care for a Significant Change	"Reasons for completion" section on the POC was updated to include Significant Change in Condition CMs educated to complete POC when changes in condition were identified.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Member was identified for transfer to HCBS and was offered options	Training will be developed regarding the discussion of community options. Training to be completed by the managers during weekly huddle. Additional training will be provided with the roll-out of the revised Options Counseling form.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager's participation in at least one Facility Interdisciplinary Team (IDT) meeting	Scheduling of IDT will be reinforced during huddles and 1:1 supervisory meeting. Nursing Facility Process revised to include the participation in at least 1 IDT per year. CMs completed telephonic outreach facilities requesting dates/times of IDTs. Re-Activation of the IDT report	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM	The POC was revised to include documentation for those cognitively impaired and unable to answer the questions.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Review for elements that scored below 86%: Member was present at each telephonic visit	The POC was revised to include documentation for the POA/Caregiver to sign if the member is cognitively impaired. Monthly audits to ensure documentation completed.	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Timely Telephonic Review of Member Placement and Services	Requisitions are opened in Human Resources to align staff with increased enrollment. The POC report is pulled weekly for review. Metrics were added to the quality audit to ensure timeframe compliance. All those that fall out of specified timeframe are reviewed with the CM.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager explained and discussed any payment liability	The CM confirms with the facility personnel that they have discussed required sections with the member. Statement added to the revised POC. Nursing Facility process was revised to include the payment liability.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: 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	POC was revised to include a place for quarterly review documentation. Discuss with the member/POA to mail back the signed POC in the self-addressed/sampled envelope to the Health Plan POC will be revised to add the reminder statement.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager reviewed the Member's Rights and Responsibilities	The POC was revised to include documentation for those cognitively impaired and unable to answer the questions. The POC was revised to include documentation for the POA/Caregiver to sign if the member is cognitively impaired. POC will be revised to add the reminder statement.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Care Manager educated the Member on how to file a grievance and/or an appeal	The POC was revised to include documentation for those cognitively impaired and unable to answer the questions. The POC was revised to include documentation for the POA/Caregiver to sign if the member is cognitively impaired. POC will be revised to add the reminder statement.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%: Member and/or representative had training on how to report a critical incident	1. The POC includes documentation that member/representative was trained how to report a Critical Incident for those cognitively impaired and unable to answer the questions. 2. The POC was revised to include documentation for the POA/Caregiver to sign if the member is cognitively impaired. 3. POC will be revised to add the reminder statement.	Addressed
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2022 CM Review for elements that scored below 86%	Recommendation Response- Plan of Care audits occur monthly, the checklist includes review of the Facility's Plan of Care is in the members file, that the Individualized Plan of Care is established in association with the Member and that a copy of those documents is mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program. The MLTSS management team continues to monitor POC completion report weekly and meet with the individual CMs monthly to ensure timely completion with the initial POC within 45 days and ensuring members have a copy. Re-education and assistance with visit prioritization are provided to CM staff by manager as needed during 1:1 meeting. The Plan of Care report are reviewed by the managers on a weekly basis. Clinical audits were initiated to ensure POC was completed for each member. The clinical audit tool revised to ensure congruency between POC and the authorized services. The Plan of Care was reformatted to ensure documentation for all formal services. Reinforced the POC should be completed on all members initially, with every touchpoint and change in condition. Reinforcement of Plan of Care acknowledgement including signature, date and/or authorized representative was conducted with each Case Manager as well as in the formal training. Member's needs or change in condition is addressed in updated Plan of Care changes aligning with member's current or changing needs. Requisitions are opened in Human Resources to align staff with increased enrollment. The POC report is pulled weekly for review. Metrics were added to the quality audit to ensure timeframe compliance. All those that fall out of specified timeframe are reviewed with the CM. Members displaying disagreement with the with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) will be counseled by the Care Manager related to a written notice of action that will explain the member's rights to file an appeal. United Healthcare will certify that the Care Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting. Critical Incident training is completed during on boarding and then annually with a required post-test.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve. United is committed to reviewing and revising the Gaps in Care for PCS Provides and Service Delivery Providers job aid to provide more structure to the process. UHC has created a dedicated team to review the gaps in care daily. UHC has a dedicated team that communicates gaps in care to the Care Manager as applicable and the report for Gaps in Care per claims is in development for Manager/Care Manager review. Plan of Care was reformatted to ensure documentation for all formal services, to include PERS. Training on the revised Plan of Care provided for all staff. UHC developed a POC report that is reviewed the managers on a weekly basis. Clinical audits were initiated to ensure POC was completed on each member. Clinical audit tool revised to ensure congruency between POC, and the authorized services and the Plan of Care was reformatted to ensure documentation for all formal services.	

[1] **Addressed**: Managed care organization (MCO)'s quality improvement (QI) corrective action plan (CAP) response addressed the deficiency; IPRO will monitor implementation in contract year (CY) 2024. **Remains an opportunity for improvement**: MCO's QI response did not address the recommendation; improvement was not observed or performance declined.

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

Tables 61–65 highlight each MCO's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of the EQR activities conducted in 2023 as they relate to **quality**, **timeliness**, and **access**.

ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 61: ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2023 PIPs	Out of the three (3) PIPs scored, two (2) PIPs performed at or above the 85% threshold for Core Medicaid and one (1) PIP scored at or above 86% threshold for MLTSS indicating high performance.	Overall, ABHNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of Performance Indicator results and additional interventions that specifically address barriers identified. In addition, all calculations should be reviewed and verified prior to submitting PIP reports.
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022 to June 30, 2023*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2023, ten (10) standards received 100% compliance. One (1) standard received 89% compliance.	Three (3) standards, ranging from 55% to 67% did not meet compliance. Those measures were: Disenrollment (67%) Availability of services (67%) Coordination and continuity of Care (55%)
HEDIS MY 2022 Performance Measures	ABHNJ reported significant improvements (a more than five percentage point change is considered a significant change) in performance for five (5) HEDIS measures.	ABHNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for eight (8) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2023)	Two (2) of eight (8) Adult CAHPS measures were at or above the 75th percentile. One (1) of eight (8) Child CAHPS measure fell between the 50th and 75th percentiles.	Six (6) of eight (8) Adult CAHPS measures fell below the 50th percentile. Seven (7) of eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2023 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, ABHNJ scored over the 85% threshold in nine (9) categories ranging from 89% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, ABHNJ scored below the 85% threshold in four (4) categories ranging from 56% to 73%.
MLTSS – 2023 HCBS CM Review	Of the 6 categories at the sub-population level, ABHNJ scored at or above 86% for 11 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, ABHNJ scored below 86% for 6 of the 17 sub-populations scores.
MLTSS – 2023 NF CM Review	Of the 20 elements for which sufficient denominators were observed, ABHNJ scored at or above 86% for four (4) elements.	Of the 21 elements for which sufficient denominators were observed, ABHNJ had 17 review elements that scored below 86%.
Recommendations		
2023 PIPs	ABHNJ should address the PIP validation elements that were determined to be partially met.	
2023 Compliance with Medicaid and CHIP Managed Care Regulations	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. The MCO should continue to address pediatric specialist access in the identified counties by pursuing contracts with applicable providers. 2. A4e. The MCO should continue to address hospital access in Warren County by finalizing	

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
*(*July 1, 2022, to June 30, 2023*)*	negotiations with St. Luke's Hospital. 3. A7. The MCO should continue to focus on improving specialist – urgent care, behavioral health, and OB/GYN at-risk appointment availability and PCP after-hours availability. 4. The MCO should consider re-defining its appointment availability standard (goal) to 90%. **Member Disenrollment** 1. MD2. The MCO should update its Member Handbook and/or Member Disenrollment policy to list the specific good cause reasons for member disenrollment requests. 2. MD3. The MCO should update its Member Rights and Responsibilities policy to specifically address that it does not discriminate based on creed, religion, ancestry, marital status, sexual orientation, or gender identity. 3. MD4. The MCO should update its Member Disenrollment/Disruptive Member Transfer policy to specifically address situations when the enrollee is out of State for care provided/authorized by the Contractor, full-time students, or Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P. 4. MD19. The MCO should update its Member Disenrollment/Disruptive Member Transfer policy to specifically address instances when the MLTSS member declines to consent to care management services. **Credentialing and Re-credentialing** 1. CR8. The MCO should ensure its processes and policies include the review of performance indicators, utilization management statistics, Member grievances, and critical incidents during the re-credentialing process. **Utilization Management** 1. UM16h: Member Appeals/MLTSS, the MCO should ensure that the correct information is in the resolution letter and resolution letters are timely.
HEDIS MY 2022 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS 2023)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2023 CM Review	For the General Population: 1. CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed. 2. CM3: For New and Existing Enrollees, ABHNJ should ensure that they appropriately identify Enrollees with potential CM needs. 3. CM6: ABHNJ should ensure that the IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only), and when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only). 4. CM7: ABHNJ should ensure the Comprehensive Needs Assessment is completed timely, within 30 days following an IHS score of 5 or greater. 5. CM14: ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and status is confirmed by a reliable source. ABHNJ should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above). ABHNJ should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20).

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	6. CM15: ABHNJ should ensure that for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. 7. CM17: For Enrollees who are given a treatment plan, ABHNJ should ensure that the treatment plan progresses in a timely manner without unreasonable interruption. For the DDD Population: 1. CM14: ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sent EPSDT reminders. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees (aged 19 and above). For Enrollees (aged 1 through 20), ABHNJ should ensure that a dental visit occurs during the review period, and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months). For the DCP&P Population: 1. CM7: ABHNJ should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment). 2. CM8: ABHNJ should ensure the Enrollee's completed Care Plan includes all required components. 3. CM11: ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. 4. CM14: ABHNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sends EPSDT reminders. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. For Enrollees (aged 1 through 20), ABHNJ should ensure a dental visit occurs during the review period and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).
MLTSS – 2023 HCBS CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B.**
MLTSS – 2023 NF CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B**.

AGNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 62: AGNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2023 PIPs	Out of three (3) PIPs scored, two (2) PIPs performed at or above the 85% threshold for Core Medicaid and one (1) PIP scored at or above 86% threshold for MLTSS indicating high performance.	Overall, AGNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring statistical techniques described in the data analysis plan are actually conducted in the analysis and ensuring consistency in Aim Statement and Goal rates (percentage change versus percentage point change).

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2023, nine (9) standards received 100% compliance. One (1) standard received 94% compliance.	Four (4) standards, ranging from 0% to 78%, did not meet compliance. Those measures were: Disenrollment (78%) Availability of services (58%) Coordination and continuity of Care (55%) Assurances of adequate capacity and services (0%)
HEDIS MY 2022 Performance Measures	AGNJ reported significant improvements (a more than five percentage point change is considered a significant change) for eleven (11) HEDIS measures.	AGNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for five (5) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2023)	Two (2) of eight (8) Adult CAHPS measures were at or above the 75th percentile. Four (4) of eight (8) Adult CAHPS measures fell between the 50th and 75th percentiles. Two (2) of eight (8) Child CAHPS measures fell at or above the 75th percentile and four (4) of eight (8) measures fell between the 50th and 75th percentiles.	Two (2) of eight (8) Adult CAHPS measures fell below the 50th percentile. Two (2) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2023 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, AGNJ scored over the 85% threshold in six (6) categories ranging from 95% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, AGNJ scored below the 85% threshold in seven (7) categories ranging from 46% to 83%.
MLTSS – 2023 HCBS CM Review	Of the 6 categories at the sub-population level, AGNJ scored at or above 86% for 12 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, AGNJ scored below 86% for 5 of the 17 sub-populations scores
MLTSS – 2023 NF CM Review	Of the 21 elements for which sufficient denominators were observed, AGNJ scored at or above 86% for 16 elements.	Of the 21 elements for which sufficient denominators were observed, AGNJ had five (5) review elements that scored below 86%.
Recommendations		
2023 PIPs	AGNJ should address the PIP validation elements that were determined to be partially met.	
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4. The MCO should ensure to provide DMAHS with a certified provider network file on a quarterly basis. 2. A4a. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County. 3. A4c. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Cape May, Mercer, Monmouth, Ocean, and Warren counties. 4. A4d. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Cape May, Hunterdon, Middlesex, Monmouth, Salem, Somerset, Sussex and Warren Counties. 5. A4d. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pedodontists in Atlantic, Cape May, Mercer, Monmouth, Somerset and Sussex Counties. 6. A4e. The MCO should continue to address hospital deficiencies in Hunterdon County. 7. A7. The MCO should focus on improving appointment availability for OB-GYNs, Other Specialists, Urgent Specialty care, Behavioral Health Prescribers, Behavioral Health Non-Prescribers as well as PCP after-hours non-compliance.	

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	Quality Management 1. QM11a. For the Core Medicaid MCO Adolescent Risk Behaviors and Depression Collaborative PIP the MCO did report the year end data for the Performance Indicators, however it was not evident that the interventions supporting the outcomes cited were sustainable. The MCO should have provided the quarterly data which supports the sustainability of the outcomes presented as evidence of the interventions utilized. As a Final Report, the MCO should have also detailed Lessons Learned, identifying the key issues that assisted in moving the PIP for future Performance Improvement Projects. 2. QM11a. For Improving Well Child Visits and Immunization Rates for members 0-30 months, the MCO should have used MY 2021 for the Baseline Rates inclusive of numerator and denominator. The MCO should have updated the information for the Baseline and corresponding Tables/ Sections that were impacted by not using the 2021 Baseline as guided. This discrepancy led to the misalignment with the Objective, Aim, and Goals of the PIP which may have delayed progress toward the outcomes. 3. QM11b. For the MLTSS PIP Reduction in Falls among Home and Community Based members in MLTSS. There were miscalculations when updating data that remained in the Final Report. A correction was made to the HCBS value, however the total number of unique members remained unchanged. This one miscalculation also impacted the FRA Unique member percentage value and could be carried through the PIP. The MCO should have reviewed each section for all metrics, ensuring that all data were represented in a clear and concise manner, identifying the rational for changes and updates in the tables and in the discussion sections to ensure the accuracy of the information that carries through each measurement year through the life of the PIP. 4. QM11b. For the MLTSS PIP Decreasing Gaps in Care in Managed Long Term Services and Supports, there were inconsistencies in numeric formats and values and insufficient data presented to evaluate year-over-year progress. Data challenges were noted, but no solutions were identified. In addition, the MCO did not exhibit an understanding of progress made in performance indicators and its sustainability over time. The MCO should have reviewed each PIP section for all metrics, ensuring that all data were represented in a clear and concise manner, identifying the rationale for changes and updates in the tables and in the discussion sections to ensure the accuracy of the information that carries through each measurement year through the life of the PIP. **Satisfaction** 1. S5. The MCO should ensure to perform random quarterly surveys to members to verify the enrollees understanding of procedures and services available to new members. 2. S5. The MCO should establish a method for tracking and scoring the quarterly calls to new members and have available for review by DMAHS and/or the EQRO upon request at regularly scheduled site visits. **Member Disenrollment** 1. MD2. The MCO should ensure that their policy or Member Handbook should be updated to list specific good cause reasons as outlined in the Contract language. 2. MD4. The MCO should ensure that their policy or Member Handbook should be updated to list specific out of state exceptions as outlined in the Contract language. **Management Information Systems** 1. IS15.The MCO should ensure that appropriate staff with knowledge of the systems are available to demonstrate MCO compliance with the standard. Additionally, MLTSS staff who have a daily working knowledge of how the systems are used should be available to participate in the review.

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	2. IS17. In their narrative and documentation, the MCO relied on processes related to provider or member notification of failure to deliver services. In discussion, they do have a system-based Service Delivery Verification process. It was unclear how the MCO uses the information from this system in real time to ensure that services are delivered timely and that service interruptions are addressed in a timely manner. The MCO should expand its use of the system-based notification process and should develop and document protocols to ensure that the information from this system is used in a timely manner to address and correct failure to deliver services.
HEDIS MY 2022 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, AGNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS 2023)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2023 CM Review	For the General Population: 1. CM2: AGNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed. 2. CM3: For New and Existing Enrollees, AGNJ should ensure that they appropriately identify Enrollees with potential CM needs. 3. CM5: AGNJ should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee. 4. CM7: AGNJ should ensure that Initial outreach to complete a CNA is done. 5. CM8: AGNJ should ensure that the Care Plan is developed within 30 days of CNA completion, and the Care Plan includes all the required components. 6. CM14: AGNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. AGNJ should ensure the Enrollee's (aged 0 through 18) immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. AGNJ should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above) and aggressive outreach attempts are documented to confirm immunization status. AGNJ should ensure that dental needs are addressed for Enrollees (aged 21 and above). For Enrollees (aged 1 through 20), AGNJ should ensure that a dental visit occurs during the review period. 7. CM15: For Enrollees demonstrating needs requiring a treatment plan, AGNJ should ensure the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. For the DDD Population: 1. CM11: AGNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. 2. CM14: AGNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. AGNJ should ensure the Enrollee's (aged 0 through 18), immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. AGNJ should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above). AGNJ should ensure that dental needs are addressed for Enrollees (aged 21 and above). For Enrollees (aged 1 through 20), AGNJ

AGNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	should ensure that a dental visit occurs during the review period and dental reminders are sent. 3. CM15: For Enrollees demonstrating needs requiring a treatment plan, AGNJ should ensure the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. For the DCP&P Population: 1. CM7: AGNJ should ensure that outreach for CNA is done timely within 45 days of enrollment. 2. CM11: AGNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. 3. CM14: AGNJ should ensure the Enrollee's (aged 0 through 18) immunizations are up to date and immunization status is confirmed by a reliable source. For Enrollees (aged 1 through 20), AGNJ should ensure that a dental visit occurs during the review period.
MLTSS – 2023 HCBS CM Review	AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.
MLTSS – 2023 NF CM Review	AGNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.

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

Table 63: FC/WCHP – Strengths and Opportunities for Improvement, and EQR Recommendations

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2023 PIPs	Out of the three (3) PIPs scored, two (2) PIPs scored at or above the 85% threshold for Core Medicaid indicating high performance. One PIP (1) scored below the 86% threshold for MLTSS.	One (1) MLTSS PIP scored below the 86% threshold. Overall, FC/WCHP was partially compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring barrier analyses are comprehensive and drive appropriate interventions and sufficiently addressing factors that impact external validity of Performance Indicator results.
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2023, ten (10) standards received 100% compliance.	Four (4) standards, ranging from 0% to 73% did not meet compliance. Those measures were: Coordination and continuity of Care (73%); Availability of services (58%) Grievance and appeal systems (56%) Assurances of adequate capacity and services (0%)
HEDIS MY 2022 Performance Measures	FC/WCHP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for four (4) HEDIS measures.	FC/WCHP reported significant declines (a more than five percentage point change is considered a significant change) in rates for ten (10) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2023)	Four (4) of eight (8) Adult CAHPS measures were between the 50th and 75th percentiles. One (1) Adult CAHPS measure scored greater than or equal to 90th percentile.	Three (3) of eight (8) Adult CAHPS measures fell below the 50th percentile. Eight (8) of eight (8) Child CAHPS measures fell below the 50th percentile.

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Core Medicaid - 2023 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, FC/WCHP scored over the 85% threshold in six (6) categories ranging from 86% to 95%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, FC/WCHP scored below the 85% threshold in seven (7) categories ranging from 46% to 78%.
MLTSS – 2023 HCBS CM Review	Of the 6 categories at the sub-population level, FC/WCHP scored at or above 86% for 15 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, FC/WCHP scored below 86% for two (2) of the 17 sub-populations scores.
MLTSS – 2023 NF CM Review	Of the 21 elements for which sufficient denominators were observed, FC/WCHP scored at or above 86% for 16 elements.	Of the 21 elements for which sufficient denominators were observed, FC/WCHP had five (5) review elements that scored below 86%.
Recommendations		
2023 PIPs	FC/WCHP should address the PIP validation elements that were determined to be partially met.	
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4. The MCO should develop policies and procedures to address requirements of section 1902(kk) provider screening and enrollment, including termination of any provider immediately upon State notification that the provider cannot be enrolled or when the 120-day time period has expired. 2. A4b. The MCO should continue to address pediatric PCP access in Sussex County by pursuing contracts with applicable providers. 3. A4c. The MCO should continue to address pediatric specialist access in identified counties by pursuing contracts with applicable providers. 4. A4d. The MCO should continue to address general dentist access in Burlington, Hudson, and Sussex Counties by pursuing contracts with applicable providers. 5. A4e. The MCO should continue to address hospital access in Burlington County by pursuing contracts with applicable providers. 6. A7. The MCO should continue to focus on improving behavioral health care provider routine, urgent, and emergency appointment availability. **Quality Management** 1. QM11a. For the Core Medicaid Adolescent Risk Behaviors and Depression Collaborative PIP, the MCO should continue to identify opportunities to implement robust interventions to improve outcomes. For the Core Medicaid Improving Early and Periodic Screening Diagnostic and Treatment (EPSDT) Well Child Visits and Childhood Immunizations PIP, the MCO should ensure all data/results are reported accurately and significant barriers are identified and addressed. 2. QM18. The MCO should ensure that its FIDE SNP population is included in MY 2023 HEDIS, NJ Specific, and Core Set measure reporting. 3. QM19. The MCO should submit performance measures timely and accurately according to the appropriate Waiver Year Timeline provided. **Member Disenrollment** 1. MD20. The MCO should update its MLTSS Disenrollment Request Step Action document to include written notification requirements for members who decline to consent to clinical eligibility reassessment or face-to-face visits after counseling and a minimum of two contacts to obtain consent. **Credentialing and Recredentialing** 1. CR9. The MCO should ensure MLTSS providers submit an attestation as evidence for conducting criminal background checks as per Contract requirements.	

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	Utilization Management 1. UM16b. Provider Grievance Core Medicaid - The MCO should ensure that provider grievance resolution timeliness is met (within 30 days). 2. UM16d. Provider Appeals Core Medicaid - The MCO should ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files. 3. UM16g. Provider Grievance MLTSS - The MCO should ensure that provider grievance resolution timeliness is met (within 30 days). 4. UM16i. Provider Appeals MLTSS – The MCO should ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files.
HEDIS MY 2022 Performance Measures	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, FC/WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.
Quality of Care Surveys – Member (CAHPS 2023)	1. The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2023 CM Review	FC/WCHP should address the deficiencies noted in the following areas: For the General Population: 1. CM3: Fidelis Care should ensure that New and Existing Enrollees with potential CM needs are appropriately identified. 2. CM6: Fidelis Care should ensure that for New Enrollees, an IHS is completed within 45 days of enrollment, and aggressive outreach is attempted and documented when initial outreach is unsuccessful, within 45 days of the Enrollee's enrollment. 3. CM8: Fidelis Care should ensure the Care Plan is completed for the Enrollee and includes all required components. 4. CM14: Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. Fidelis Care should ensure immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. Fidelis Care should ensure for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status. For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period. For the DDD Population: 1. CM7: Fidelis Care should ensure that initial outreach to complete CNA is timely, within 45 days of Enrollee's enrollment. 2. CM7: Fidelis Care should ensure a level of Care Management is determined for the Enrollee. 3. CM8: Fidelis Care should ensure a Care Plan is completed for the Enrollee and includes all required components. 4. CM14: Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. Fidelis Care should ensure that for Enrollees (aged 19 and above), appropriate vaccines have been administered, and aggressive outreach attempts are documented to confirm immunization status. Fidelis Care should ensure that for

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	Enrollees (aged 21 and above), dental needs are addressed. Fidelis Care should ensure that a dental visit occurs for Enrollees (aged 1 through 20) during the review period. 5. CM15: Fidelis Care should ensure for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. 6. CM17: For Enrollees who are given a treatment plan, Fidelis Care should ensure that the treatment plan progresses in a timely manner without unreasonable interruption. 7. CM19: When appropriate for the applicable Enrollees, Fidelis Care should ensure that the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD), and that documentation of all contacts and linkages, to medical and other services, in are in the Enrollee's case files. For the DCP&P Population: 1. CM7: Fidelis Care should ensure that the outreach to complete a CNA and the completion of the CNA occurs timely, within 45 days of Enrollee's enrollment. 2. CM14: Fidelis Care should ensure that aggressive outreach attempts are documented to confirm EPSDT status and EPSDT reminders are sent for Enrollees (aged 0 through 20). Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period, the Care Manager makes attempts to obtain dental status, and dental reminders are sent.
MLTSS – 2023 HCBS CM Review	FC/WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F.**
MLTSS – 2023 NF CM Review	FC/WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.

HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

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

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2023 PIPs	Out of the three (3) PIPs scored, two (2) PIPs performed at or above the 85% threshold for Core Medicaid and one (1) PIP scored at or above 86% threshold for MLTSS indicating high performance.	Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of Performance Indicator results and disparities presented. In addition, all calculations should be reviewed and verified prior to submitting PIP reports.
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2023, ten (10) standards received 100% compliance. Two (2) standards received 89% compliance.	Two (2) standards, ranging from 64% to 75%, did not meet compliance. Those measures were: Availability of services (75%) Coordination and continuity of Care (64%);
HEDIS MY 2022 Performance Measures	HNJH reported significant improvements (a more than five percentage point change is considered a significant change) in rates for six (6) HEDIS measures.	HNJH reported significant declines (a more than five percentage point change is considered a significant change) in performance for four (4) HEDIS measures.

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care Surveys – Member (CAHPS 2023)	Three (3) of eight (8) Adult CAHPS measures were at or above the 75th percentile. Two (2) of eight (8) Adult CAHPS measures fell between the 50th and 75th percentiles.	Three (3) of eight (8) Adult CAHPS measures fell below the 50th percentile. All eight (8) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2023 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, HNJH scored over the 85% threshold eight (8) categories ranging from 86% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, HNJH scored below the 85% threshold in five (5) categories ranging from 61% to 84%.
MLTSS – 2023 HCBS CM Review	Of the 6 categories at the sub-population level, HNJH scored at or above 86% for 14 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, HNJH scored below 86% for 3 of the 17 sub-populations scores.
MLTSS – 2023 NF CM Review	Of the 21 elements for which sufficient denominators were observed, HNJH scored at or above 86% for 18 elements.	Of the 21 elements for which sufficient denominators were observed, HNJH had three (3) review elements that scored below 86%.
Recommendations		
2023 PIPs	HNJH should address the PIP validation elements that were determined to be partially met.	
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Camden, Cape May, Cumberland, Mercer, Monmouth, Ocean, Sussex, and Warren counties. 2. A4d. The MCO should continue to expand the Dental network in Hunterdon and Warren Counties. 3. A7. The MCO should focus on improving appointment availability for adult PCPs, Specialists, OB/GYNs, Dental providers, and Behavioral Health providers, as well as improve PCP after-hours availability. **Quality Management** 1. QM18. The MCO should ensure to submit performance measures timely, or as directed by DMAHS and the EQRO. **Member Disenrollment** 1. MD2. The MCO should ensure that their policy or Member Handbook is updated to list specific good cause reasons as outlined in the Contract language. 2. MD9. The MCO should update the Disenrollment policy to address the required Contract language. **Utilization Management** 1. UM16g. The MCO should ensure timeliness adherence regarding MLTSS Provider Grievances Resolution letters.	
HEDIS MY 2022 Performance Measures	1. The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	
Quality of Care Surveys – Member (CAHPS 2023)	The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	
Core Medicaid - 2023 CM Review	For the General Population:	

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. CM3: For New and Existing Enrollees, HNJH should ensure that they appropriately identify Enrollees with potential CM needs. 2. CM6: HNJH should ensure that an IHS is completed within 45 days of enrollment for Enrollees, and aggressive outreach should be attempted and documented when initial outreach is unsuccessful within 45 days of the Enrollee's enrollment. 3. CM7: HNJH should ensure that initial outreach to complete a CNA is done, and the Comprehensive Needs Assessment (CNA) is completed timely, (within 30 days following an IHS score of 5 or greater). 4. CM8: HNJH should ensure the Care Plan is completed within 30 days of CNA completion, and the Care Plan contains all required components. 5. CM14: HNJH should ensure Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity schedule and status is confirmed by a reliable source. HNJH should ensure Enrollee's (aged 0 through 18) immunizations are up to date and immunization status is confirmed by a reliable source. HNJH should ensure aggressive outreach attempts are documented to confirm immunization status for Enrollees (aged 0 through 18). For Enrollees (aged 19 and above), HNJH should ensure that appropriate vaccines are administered, and aggressive outreach attempts are documented to confirm immunization status. HNJH should ensure that dental needs are addressed for Enrollees (aged 21 and above). HNJH should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20). 6. CM15: HNJH should ensure for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. For the DDD Population: 1. CM7: HNJH should ensure that the Comprehensive Needs Assessment (CNA) is completed timely (within 45 days of the Enrollee's enrollment). 2. CM11: HNJH should ensure the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. 3. CM14: HNJH should ensure that immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. HNJH should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above). HNJH should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20). For the DCP&P Population: 1. CM7: HNJH should ensure that the Comprehensive Needs Assessment (CNA) is completed timely (within 45 days of the Enrollee's enrollment). 2. CM11: HNJH should ensure the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. 3. CM14: HNJH should ensure aggressive outreach attempts are documented to confirm immunization status for Enrollees (aged 0 through 18). HNJH should ensure that a dental visit occurs during the review period for Enrollees aged (1 through 20).
MLTSS – 2023 HCBS CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D.**
MLTSS – 2023 NF CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D**.

UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

Table 65: UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2023 PIPs	Out of the three (3) PIPs scored, two (2) PIPs performed at or above the 85% threshold for Core Medicaid and one (1) PIP scored at or above 86% threshold for MLTSS indicating high performance.	Overall, UHCCP was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring all available data are included for analysis of Performance Indicator results.
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2023, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 64% to 67% did not meet compliance. Those measures were: Availability of services (67%) Coordination and continuity of Care (64%);
HEDIS MY 2022 Performance Measures	UHCCP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for seven (7) HEDIS measures.	UHCCP reported significant declines (a more than five percentage point change is considered a significant change) in rates for five (5) HEDIS measures.
Quality of Care Surveys – Member (CAHPS 2023)	One (1) of eight (8) Adult CAHPS fell between the 50th and 75th percentiles. Two (2) Child CAHPS measure were at or above the 75th percentile and three (3) fell between the 50th and 75th percentiles.	Seven (7) of eight (8) Adult CAHPS measures fell below the 50th percentile. Three (3) Child CAHPS measures fell below the 50th percentile.
Core Medicaid - 2023 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, UHCCP scored over the 85% threshold in nine (9) categories ranging from 87% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, UHCCP scored below the 85% threshold in four (4) categories ranging from 57% to 83%.
MLTSS – 2023 HCBS CM Review	Of the 6 categories at the sub-population level, UHCCP scored at or above 86% for four (4) of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, UHCCP scored below 86% for 13 of the 17 sub-populations scores.
MLTSS – 2023 NF CM Review	Of the 21 elements for which sufficient denominators were observed, UHCCP scored at or above 86% for nine (9) elements.	Of the 21 elements for which sufficient denominators were observed, UHCCP had 12 review elements that scored below 86%.
Recommendations		
2023 PIPs	UHCCP should address the PIP validation elements that were determined to be partially met.	
2023 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2022, to June 30, 2023*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. The MCO should continue to focus its efforts on provider recruitment in order to improve Pediatric Specialist access in all counties, except Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, and Union. 2. A4d. The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Hunterdon and Warren Counties. 3. A4f. The MCO should continue to expand the MLTSS network to include at least two providers in every County for Assisted Living Program. 4. A7. The MCO should focus on improving appointment availability for OB-GYN providers, Dental providers, and Behavioral Health providers, as well as PCP after-hours compliance. **Quality Management** 1. QM 11b. The MCO should ensure that the Barrier Analysis, Table 1a is in alignment with Table 1b, Quarterly Reporting Rates for Intervention Tracking Measures (ITMs). Changes made to an ITM can change the impact of a measure, even by adding a few words. The	

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	MCO should ensure alignment between tables for an accurate and comprehensive evaluation of Interventions/ITMs over the life of the PIP.
HEDIS MY 2022 Performance Measures	Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
Quality of Care Surveys – Member (CAHPS 20223)	The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.
Core Medicaid - 2023 CM Review	UHCCP should address the deficiencies noted in the following areas: For the General Population: 1. CM2: UHCCP should ensure that adequate discharge planning is performed for Enrollees who are hospitalized. 2. CM3: For New and Existing Enrollees, UHCCP should ensure that they appropriately identify Enrollees with potential CM needs. 3. CM6: UHCCP should ensure that when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment. 4. CM7: UHCCP should ensure that a level of Care Management is determined for the Enrollee. 5. CM8: UHCCP should ensure that a Care Plan is completed for the Enrollee that includes all required components. 6. CM14: UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. For Enrollees (aged 19 and above), UHCCP should ensure that appropriate vaccines have been administered, and aggressive outreach attempts were documented to confirm immunization status. UHCCP should ensure that a dental visit occurred during the review period for Enrollees (aged 1 through 20). For the DDD Population: 1. CM7: UHCCP should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment). 2. CM14: UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. UHCCP should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above). UHCCP should ensure that dental needs are addressed for Enrollees (aged 21 and above). For Enrollees (aged 1 through 20), UHCCP should ensure that a dental visit occurs during the review period. For the DCP&P Population: 1. CM7: UHCCP should ensure the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). 2. CM14: UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. For Enrollees (aged 1 through 20), UHCCP should ensure that a dental visit occurs during the review period.
MLTSS – 2023 HCBS CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E.**
MLTSS – 2023 NF CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E**.

Appendix A: January 2023 – December 2023 NJ MCO-Specific Review Finding

Note: This is a separate document.

Appendix B: ABHNJ 2023 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix C: AGNJ 2023 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix D: HNJH 2023 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix E: UHCCP 2023 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix F: FC/WCHP 2023 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix G: Submission Guides for 2023 Annual Assessment Review, Member Disenrollment and 2023 Care Management Audits (Core Medicaid and MLTSS)

Note: This is a separate document.

APPENDIX A: January 2023–December 2023 MCO-Specific Review Findings (2023 – 2024 Reporting Cycle)

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Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	21	9	0	21	70%
Care Management and Continuity of Care – MLTSS*	10	10	10	10	0	0	0	100%
Access	14	4	10	7	3	0	11	79%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	12	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	32	12	12	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment[5]	29	N/A	29	25	4	0	25	86%
Credentialing and Re-credentialing	10	7	3	2	1	0	9	90%
Utilization Management	30	16	14	13	1	0	29	97%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**228**	**112**	**116**	**107**	**9**	**0**	**219**	**96%**

[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.

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

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

[5] Member Disenrollment is a new category reviewed in 2023.

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

ABHNJ Performance Improvement Projects

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

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

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

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 3, 2023
Reporting Period: Year 2

IPRO Comments:
Element 1 Overall Review Determination was that the MCO is partially compliant regarding 1a. Attestation signed & Project Identifiers Completed. The MCO should ensure that all appropriate leadership signs the attestation prior to submission. On page 5, the CEO did not sign the attestation for Year 2.

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant regarding element 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). Miscalculations were identified on page 27, Y1-2022 Q4, 2d, on page 33, in the narrative, ITM 5b, 667/5947 should be 11.22%, and on page 41, baseline period 2021, 2,331/122,951 * 1000 should be 18.96. The MCO should review all calculations in the tables and narrative for accuracy prior to final report submission in August 2024.

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

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

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

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70.0 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO should consider clarifying how ED visit counts are not duplicated, since they are counting hospital and professional claims. The MCO should consider adding practice-level provider results to the analysis. The MCO continues to demonstrate collaboration with provider practices and there is some evidence that these activities are impacting performance indicators. Passive member interventions do not appear to have been successful to date and the MCO indicates these will continue to be monitored. In the Results Table 2, pg. 41, and the discussion on pg. 42, the MCO discusses the movement of each Performance Indicator from the Baseline through present, including interim data for the first 3 months of 2023, however, the MCO should explain further the significant variance between PI #1, all PCPs in the Medicaid network and targeted PCP in Medicaid network and PI #2, Targeted adult PCPs in the Medicaid network. The PCP utilization for all PCPs is more than double the utilization for targeted PCPs across baseline and Years 1 and 2. The MCO should review the above comments and update them for a complete and comprehensive evaluation of the PIP in the August 2024 Report submission.

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

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

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

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: September 21, 2023
Reporting Period: Year 2

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant, regarding element 5d, with corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). On page 20, Y1 Q4, ITM 1a, 78/153 is listed as 50.998%. On page 23, Y1 Q3, 31/161 is listed as 19.26%. The MCO should ensure all calculations are reviewed prior to submission for accuracy.

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

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

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

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed healthcare disparities in this PIP, identifying disparities in utilization in the African-American membership and focused on provider practices with a significant African-American panel. The MCO recognized that changes in HEDIS methodology from CIS9 to CIS10 could impact comparability of results and recalculated baseline rates using CIS10 specifications. On page 10, Objectives, in the first statement "The Plan will.... who had their EPSDT visit and Childhood Immunization Combo 10 (Formerly Combination 9) formerly Combination 9) formerly Combination 9) by their assigned PIP", the MCO should remove the redundant "Combination 9" language and update the reference to "PIP" to PCP. Initial results do show some improvement in well-child visit utilization; however, immunization utilization has continued to decline. The MCO noted that research is being conducted to address this decline. For Element 5, Robust Interventions on page 24, the MCO should provide additional detail on the incentive which was noted to be associated with Intervention #4.

ABHNJ PIP 3: Decreasing Member Grievances Related to Balanced Billing

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

PIP Topic 3: Decreasing Member Grievances Related to Balanced Billing

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

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

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

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

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org), Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 27, 2023
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, the MCO provided a comprehensive and relevant discussion of the project topic and rationale for its selection.

Element 2 Overall Review Determination was N/A. Although not scored, the MCO should review the baseline and goal rates for Indicators 2 and 3 on page 7 and clarify if these are the percentages of balance-billing grievances by each type of provider (in-network vs. out-of-network) out of the total of all grievances, and, as

such, the two percentages for these indicators should sum to 77.24%, or the percentage of the total number of balance billing grievances, and, as such, should sum to 100%. The MCO should review and update for accurate calculations.

Element 3 Overall Review Determination was N/A. Although not scored, the MCO should consider updating the Performance Indicators on pages 8 and 9 from percentages of grievances to number of grievances in each category per 1,000 members. If using percentage of grievances, the denominator period over period will change. This could lead to invalid and inaccurate assessment of improvement or decline in the measure. For example, if balance billing grievances make up 100 out of 200 grievances, the percentage would be 50%. If, in the next period, there were 100 out of 350 grievances, the percentage would be 28.5%. This would suggest false improvement in the indicator, as the actual number of grievances did not decrease over time. The MCO should review and adjust accordingly for consistent data flow and validity over the life of the PIP.

Element 4 Overall Review Determination was N/A. Although not scored, the barrier analysis (fishbone diagram) on page 31 was comprehensive and included member, provider, and MCO drivers. The MCO should consider updating the actual result of the barrier analysis (in the far right hand box) to state "member balance billing grievances", not "decrease member grievances", as the barriers identified in the diagram lead to the resulting issue.

Element 5 Overall Review Determination was N/A. Although not scored, the MCO has planned for robust interventions (Table 1b: pages 19-25) for all barriers identified and, in particular, has planned to evaluate the members understanding of benefits and services through the mPulse program. The MCO may want to consider including in the mPulse survey a question specifically regarding balance billing and what the member should do if a bill is received. The MCO should also consider including a copy of the revised cease and desist letter in the submission.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.
Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities in this PIP.

The submission of this PIP Proposal was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on Performance Indicators

ABHNJ PIP 4: Improving Coordination of Care and Ambulatory Follow up After Mental Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

PIP Topic 4: Improving Coordination of Care and Ambulatory Follow up After Mental Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**72.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**90.6%**	**0.0%**	**0.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 6, 2023
Reporting Period: Year 2

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant, regarding element 5d, With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports). The MCO notes in intervention #5 that BH UM will educate providers regarding BH appointment standards, however, there is no corresponding ITM to track if this is occurring.

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

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

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

Element 9 Overall Review Determination was that healthcare disparities are being identified and reviewed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 72.5 points, which results in a rating of 90.6% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). As the MCO noted, the denominator for this population remains small. Performance on the FUH-30-day measures has increased year-over-year for the PIP to date. The FUH- 7-day measure increased in Y1, but then decreased below baseline in Y2. The MCO notes that in many cases, communications between BH-UM and MLTSS care management have not occurred timely because discharge occurred before concurrent review was necessary. The MCO could consider a shorter concurrent review timeframe for BH admissions to potentially resolve this issue. Also, the MCO should consider provider interventions, e.g., closer collaboration with inpatient facility discharge planners to facilitate appointment scheduling. Last, the MCO should continue to address network appointment availability issues.

ABHNJ – HEDIS Audit Review Table MY 2022

Audit Review Table					
Aetna Better Health of New Jersey (Org ID: 236303, Sub ID: 15442, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2022; Date & Timestamp - 6/9/2023 11:12:17 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		84.67%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		81.02%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.32%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		70.32%	R	R	Reported
Childhood Immunization Status - IPV		84.91%	R	R	Reported
Childhood Immunization Status - MMR		83.70%	R	R	Reported
Childhood Immunization Status - HiB		84.18%	R	R	Reported
Childhood Immunization Status - Hepatitis B		83.45%	R	R	Reported
Childhood Immunization Status - VZV		83.70%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		68.86%	R	R	Reported
Childhood Immunization Status - Hepatitis A		72.99%	R	R	Reported
Childhood Immunization Status - Rotavirus		62.29%	R	R	Reported
Childhood Immunization Status - Influenza		43.07%	R	R	Reported
Childhood Immunization Status - Combo 3		62.04%	R	R	Reported
Childhood Immunization Status - Combo 7		46.96%	R	R	Reported
Childhood Immunization Status - Combo 10		29.20%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		82.97%	R	R	Reported
Immunizations for Adolescents - Tdap		84.67%	R	R	Reported
Immunizations for Adolescents - HPV		25.06%	R	R	Reported
Immunizations for Adolescents - Combination 1		82.48%	R	R	Reported
Immunizations for Adolescents - Combination 2		24.33%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		70.32%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		45.11%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		52.31%	R	R	Reported
Colorectal Cancer Screening (COL)					

Colorectal Cancer Screening (Total)		22.30%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		64.20%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		72.03%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		28.80%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		85.57%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		88.14%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		71.00%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		61.31%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		79.55%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		73.62%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		72.13%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		2.08%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		4.86%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		4.86%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		3.47%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)		60.34%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control		32.60%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		61.80%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		48.66%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		35.27%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		64.48%	R	R	Reported

Statin Therapy for Patients With Diabetes - Statin Adherence 80%		66.99%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
Diagnosed Mental Health Disorders (Total)		20.28%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		64.36%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		47.91%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		36.67%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		35.56%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		38.93%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		22.33%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		63.67%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		55.48%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Diagnosed Substance Use Disorders - Alcohol (Total)		3.31%	R	R	Reported
Diagnosed Substance Use Disorders - Opioid (Total)		3.71%	R	R	Reported
Diagnosed Substance Use Disorders - Other (Total)		4.08%	R	R	Reported
Diagnosed Substance Use Disorders - Any (Total)		7.61%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		44.44%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		23.63%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)		38.17%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)		27.27%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		20.94%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		88.21%	R	R	Reported

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		71.79%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		91.67%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		56.59%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		49.31%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		28.47%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		28.47%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.78%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		89.13%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		58.97%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain (Total)		71.38%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		9.29%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		19.52%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		2.69%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		1.79%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		5.61%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		3.53%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		64.44%	R	R	Reported
Annual Dental Visit (ADV)	Y				

Annual Dental Visit (Total)		31.91%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total (Total)		48.78%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment - Total (Total)		15.28%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		82.73%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		81.51%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		55.88%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		52.92%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		70.48%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		53.91%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
Antibiotic Utilization for Respiratory Conditions (Total)		18.40%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
Childhood Immunization Status - DTaP		56.99%	R	R	Reported
Childhood Immunization Status - IPV		72.48%	R	R	Reported
Childhood Immunization Status - MMR		79.95%	R	R	Reported
Childhood Immunization Status - HiB		74.87%	R	R	Reported
Childhood Immunization Status - Hepatitis B		32.73%	R	R	Reported
Childhood Immunization Status - VZV		79.46%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		55.88%	R	R	Reported
Childhood Immunization Status - Hepatitis A		69.21%	R	R	Reported
Childhood Immunization Status - Rotavirus		53.53%	R	R	Reported
Childhood Immunization Status - Influenza		38.50%	R	R	Reported

Childhood Immunization Status - Combo 3		23.54%	R	R	Reported
Childhood Immunization Status - Combo 7		18.49%	R	R	Reported
Childhood Immunization Status - Combo 10		10.97%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Immunizations for Adolescents - Meningococcal		77.40%	R	R	Reported
Immunizations for Adolescents - Tdap		79.27%	R	R	Reported
Immunizations for Adolescents - HPV		22.22%	R	R	Reported
Immunizations for Adolescents - Combination 1		75.72%	R	R	Reported
Immunizations for Adolescents - Combination 2		20.61%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		45.01%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
Colorectal Cancer Screening (Total)		21.88%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		36.67%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		35.56%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		49.31%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		28.47%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		28.47%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0.00%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.00%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					

Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza (19-65)		10.82%	R	R	Reported
Adult Immunization Status - Td/Tdap (19-65)		17.06%	R	R	Reported
Adult Immunization Status - Zoster (50-65)		4.42%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		16.67%	R	R	Reported
Prenatal Immunization Status - Tdap		38.51%	R	R	Reported
Prenatal Immunization Status - Combination		12.82%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2023 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	22	8	0	22	73%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access	14	4	10	4	6	0	8	57%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	10	2	0	19	90%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	4	5	5	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	2	1	0	4	80%
Enrollee Rights and Responsibilities	8	3	5	5	0	0	8	100%
Member Disenrollment[5]	29	0	29	27	2	0	27	93%
Credentialing and Re-credentialing	10	7	2	2	0	0	10	100%
Utilization Management	30	16	14	14	0	0	30	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	2	1	0	17	94%
TOTAL	**228**	**110**	**117**	**105**	**12**	**0**	**216**	**95%**

[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.

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

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

[5] Member Disenrollment is a new standard reviewed in 2023.

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

AGNJ Performance Improvement Projects

AGNJ PIP 1: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

MCO Name: Amerigroup New Jersey (AGNJ)
PIP Topic 1: Increasing Primary Care Physician (PCP) Access and Availability for Amerigroup Members

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

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	PM	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M	M	
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	
Element 4 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 4 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	
5b. Actions that target member, provider and MCO	N/A	M	M	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	M	
Element 5 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 5 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	

Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	PM	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**PM**	
Element 7 Overall Score	**N/A**	**100**	**50**	**50**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**10.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**62.5**	**70.0**	**90.0**	**0.0**
Overall Rating	**0%**	**78.1%**	**87.5%**	**90.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 3, 2023
Reporting Period: Year 3 Findings

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

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

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

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

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

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

Element 7 Overall Review Determination was that the MCO is partially compliant regarding element 7b, Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan. The MCO did not calculate the Z-test value annually as indicated in the data analysis plan on pages 12-13. The MCO should ensure that the Z-test value is calculated for the final report submission in August 2024.

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that the MCO conducted a data review and was not able to identify any healthcare disparities.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% which is above 85% ([≥ 85% being the threshold for meeting compliance]). The MCO focused on interventions for three provider practices to increase PCP visits and reduce inpatient admissions. Provider Groups #1 and #2 exhibit declines from the baseline regarding PI#1, however, PI#2 for both Provider Groups #1 and #2 is trending toward the long-term goals. Whereas Provider Group #3 exhibits favorable trending patterns toward both PI#1 and PI#2 goals. The MCO should continue to work toward the goals updating all data for the Final Report submission in August 2024.

AGNJ PIP 2: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

MCO Name: Amerigroup New Jersey (AGNJ)

PIP Topic 2: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	0	0
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M		
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M		
4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	0	0
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M		
Element 5 Overall Review Determination	**N/A**	**M**	**M**		
Element 5 Overall Score	**N/A**	**100**	**100**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	**PM**	M		
Element 6 Overall Review Determination	**N/A**	**PM**	M		
Element 6 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**0.0**	**0.0**

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes N=No)	**N/A**	**N**	**Y**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**67.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**84.4%**	**87.5%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: September 21, 2023
Reporting Period: Year 2

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

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

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

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

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

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

Element 7 Overall Review Determination was that the MCO is partially compliant, regarding element 7b, Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan. On page 12, under Data Collection and Analysis, the MCO states that "Statistical analysis will be conducted by a dedicated data analyst at least annually utilizing Z test statistical analysis in Excel", however, this was not evident in the analysis provided. The MCO should ensure that the Z-test methodology is provided on an annual basis as noted.

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

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

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 70 points, which results in a rating of 87.5%. (Which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed the issues raised in the prior PIP submissions regarding the baseline and performance indicators. The MCO did identify healthcare disparities by noting that Hispanic members in Passaic County had a disparately low compliance with well child visits and immunizations and targeting appropriate providers to address this. Overall, there was an increase in PI1 in Y1. There was a slight decrease in P2 in Y1. Y2 results are pending the final rates for 2023. For PI3, there was a decrease in Y1, but an increase trending for Y2 (2023). The MCO should continue to analyze performance and the impact of interventions and adjust these as needed to improve PIP outcomes. The MCO should also clarify terms regarding percentage rates versus percentage points in the Aim Statement and Goals for reader understanding of progress made.

AGNJ PIP 3: Decreasing Member Grievances Related to Balance Billing

MCO Name: Amerigroup New Jersey
PIP Topic 3: Decreasing Member Grievances Related to Balance Billing

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

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

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

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

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org), Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 27, 2023
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, for the project topic and rationale for selection on page 5, the MCO addressed the overall grievance process, but did not address how the topic (grievances related to balance billing) addresses member needs, care, or services, or why the topic is important to members. The MCO should specifically address how reducing balance billing grievances impacts member needs.

Element 2 Overall Review Determination was N/A. Although not scored, the MCO should consider adding Performance Indicators for in-network vs. out-of-network providers for clarity and understanding of compliance concerns regarding contracts and internal provider practices. The MCO can use 2022 grievance data as a reference/resource but should update the Baseline Year and data to 2023, including the full year of baseline data in the April submission.

Element 3 Overall Review Determination was N/A. Although not scored, the MCO should consider updating the Performance Indicator on page 7 and 8 from percentages of grievances to number of grievances in each category per 1,000 members. If using percentage of grievances, the denominator period over period will change. This could lead to invalid and inaccurate assessment of improvement or decline in the measure. For example, if balance billing grievances make up 100 out of 200 grievances, the percentage would be 50%. If, in the next period, there were 100 out of 350 grievances, the percentage would be 28.5%. This would suggest a false improvement in the indicator, as the actual number of grievances did not decrease over time. In addition, the MCO should consider changing ITM#1a and ITM#1b on page 10 to Performance Indicators and define them as mentioned above. These are actually outcome measures that would be helpful in evaluating the success of the PIP. The MCO should review and adjust accordingly for consistent data flow and validity over the life of the PIP.

Element 4 Overall Review Determination was N/A. Although not scored, the barrier analysis (fishbone diagram) on page 18 is extremely limited in terms of identifying barriers that impact the PIP topic. The MCO should identify additional obstacles faced by members and/or providers and/or the MCO. For example, the MCO could stratify subpopulations by demographic and/or clinical characteristics such as Social Determinants of Health that create a lack of understanding of the processes available to remedy a grievance. The MCO should review and update the Fishbone Diagram to ensure a full review of the grievance process to identify additional barriers related to members and providers.

Element 5 Overall Review Determination was N/A. Although not scored, the MCO should consider enhancing the interventions noted on pages 10 and 11. For example, the MCO might consider a different approach to educating in-network vs. out-of-network providers. The MCO should consider specific Customer Service interventions. Additionally, general educational efforts regarding balance billings for all members should be available. Also, the MCO should assess their members' understanding of balance billing and what to do when a bill is received. Lastly, the MCO should include the actual text message that will be sent to members in the PIP submission.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, or address healthcare disparities in this PIP.

The submission of the PIP Proposal was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should update the year on the Title page to 2024, the year of initiation of the PIP. The MCO should address the concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on Performance Indicators.

AGNJ PIP 4: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

MCO Name: Amerigroup New Jersey (AGNJ)

PIP Topic 4: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score (Y=Yes, N=No)	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes, N=No)	**N/A**	**Y**	**Y**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**0.0%**	**0.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 6, 2023
Reporting Period: Year 2

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

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

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

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

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

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

Element 7 Overall Review Determination was that the MCO is partially compliant, regarding element 7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan. The MCO did not include the statistical analysis conducted by a dedicated data analyst at least annually utilizing Z test statistical analysis in Excel.

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

Element 9 Overall Review Determination was that the MCO is implementing processes to evaluate healthcare disparities.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 70.0 points, which results in a rating of 87.5% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO's preliminary rates for PI 1 exhibit a significant increase, however PI 2 continues to exhibit declines year over year. The MCO continues to improve communications with BH facilities as well as identify additional barriers and interventions that will assist in obtaining the goals of the PIP. In Section 3, Project Topic, on page 9-10, the MCO should review the Goals and the Goals statement for alignment (a 10% increase by 2024) in terms of actual percentage versus percentage points and ensure that the Results, Table 2 are also in alignment with the Goal Statement and Goal Rates on page 9. The MCO has implemented an array of member and provider interventions to improve performance on the indicators. The MCO should continue to analyze the effectiveness of the various interventions and modify as needed to maximize overall improvement toward the Goals. The MCO should update the title of the PIP on future submissions to "Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population".

AGNJ – HEDIS Audit Review Table MY 2022

Audit Review Table					
Amerigroup New Jersey, Inc. (Org ID: 1791, Sub ID: 4308, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2022; Date & Timestamp - 6/7/2023 9:21:47 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		84.18%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		79.08%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		76.89%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		70.07%	R	R	Reported
Childhood Immunization Status - IPV		84.91%	R	R	Reported
Childhood Immunization Status - MMR		87.83%	R	R	Reported
Childhood Immunization Status - HiB		87.10%	R	R	Reported
Childhood Immunization Status - Hepatitis B		83.70%	R	R	Reported
Childhood Immunization Status - VZV		85.16%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		69.10%	R	R	Reported
Childhood Immunization Status - Hepatitis A		74.94%	R	R	Reported
Childhood Immunization Status - Rotavirus		61.56%	R	R	Reported
Childhood Immunization Status - Influenza		44.28%	R	R	Reported
Childhood Immunization Status - Combo 3		61.31%	R	R	Reported
Childhood Immunization Status - Combo 7		47.20%	R	R	Reported
Childhood Immunization Status - Combo 10		30.90%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		89.54%	R	R	Reported
Immunizations for Adolescents - Tdap		93.67%	R	R	Reported
Immunizations for Adolescents - HPV		31.39%	R	R	Reported
Immunizations for Adolescents - Combination 1		89.05%	R	R	Reported
Immunizations for Adolescents - Combination 2		29.44%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		78.10%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		54.31%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		59.69%	R	R	Reported
Colorectal Cancer Screening (COL)					

Colorectal Cancer Screening (Total)		30.95%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		60.41%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		76.02%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		30.92%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		63.08%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		77.75%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		66.70%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		63.02%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		80.90%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		79.87%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		70.03%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		0.79%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		5.14%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		5.93%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.79%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)		53.28%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control		36.74%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		58.39%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		49.64%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		34.17%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		67.48%	R	R	Reported

Statin Therapy for Patients With Diabetes - Statin Adherence 80%		64.78%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
Diagnosed Mental Health Disorders (Total)		18.75%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		60.36%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		43.75%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		35.02%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		36.75%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		28.21%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		16.90%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		61.73%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		52.16%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Diagnosed Substance Use Disorders - Alcohol (Total)		2.17%	R	R	Reported
Diagnosed Substance Use Disorders - Opioid (Total)		2.53%	R	R	Reported
Diagnosed Substance Use Disorders - Other (Total)		2.89%	R	R	Reported
Diagnosed Substance Use Disorders - Any (Total)		5.42%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		50.27%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		29.65%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)		34.53%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)		24.90%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		19.63%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		86.59%	R	R	Reported

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		69.14%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		78.57%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		62.38%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		58.40%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		41.93%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		40.93%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.58%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		89.70%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		56.46%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain (Total)		75.70%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.26%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		13.33%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.12%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.50%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		2.74%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		1.86%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		72.58%	R	R	Reported
Annual Dental Visit (ADV)	Y				

Annual Dental Visit (Total)		54.60%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total (Total)		48.55%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment - Total (Total)		13.87%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		90.02%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		83.45%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		52.85%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		54.68%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		74.86%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		61.42%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
Antibiotic Utilization for Respiratory Conditions (Total)		20.44%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
Childhood Immunization Status - DTaP		62.48%	R	R	Reported
Childhood Immunization Status - IPV		77.47%	R	R	Reported
Childhood Immunization Status - MMR		84.27%	R	R	Reported
Childhood Immunization Status - HiB		80.64%	R	R	Reported
Childhood Immunization Status - Hepatitis B		70.63%	R	R	Reported
Childhood Immunization Status - VZV		82.35%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		61.90%	R	R	Reported
Childhood Immunization Status - Hepatitis A		72.40%	R	R	Reported
Childhood Immunization Status - Rotavirus		55.75%	R	R	Reported
Childhood Immunization Status - Influenza		38.01%	R	R	Reported

Childhood Immunization Status - Combo 3		49.32%	R	R	Reported
Childhood Immunization Status - Combo 7		37.11%	R	R	Reported
Childhood Immunization Status - Combo 10		20.99%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Immunizations for Adolescents - Meningococcal		85.26%	R	R	Reported
Immunizations for Adolescents - Tdap		88.14%	R	R	Reported
Immunizations for Adolescents - HPV		27.96%	R	R	Reported
Immunizations for Adolescents - Combination 1		83.65%	R	R	Reported
Immunizations for Adolescents - Combination 2		26.51%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		54.16%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
Colorectal Cancer Screening (Total)		30.56%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		35.02%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		36.75%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		58.40%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		41.93%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		40.93%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0.00%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.00%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					

Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza (19-65)		11.73%	R	R	Reported
Adult Immunization Status - Td/Tdap (19-65)		21.44%	R	R	Reported
Adult Immunization Status - Zoster (50-65)		2.71%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		15.63%	R	R	Reported
Prenatal Immunization Status - Tdap		31.29%	R	R	Reported
Prenatal Immunization Status - Combination		9.98%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

FC/WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

FC/WCHP 2023 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	22	8	0	22	73%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access	14	4	10	4	6	0	8	57%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	9	3	0	18	86%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment[5]	29	0	29	28	1	0	28	97%
Credentialing and Recredentialing	10	7	3	2	1	0	9	90%
Utilization Management	30	16	14	10	4	0	26	87%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**228**	**113**	**115**	**100**	**15**	**0**	**213**	**93%**

[1] A total of 93 elements were reviewed in the previous review period; of these 93, 87 were Met, 6 were Not Met; 0 was N/A. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Member Disenrollment is a new standard reviewed in 2023.

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

FC/WCHP Performance Improvement Projects

FC/WCHP PIP 1: Medicaid Primary Care Physician Access and Availability

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 1: Medicaid Primary Care Physician Access and Availability

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	**PM**	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**72.5**	**90.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**90.6%**	**90.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 3, 2023
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant regarding element 8b, sustained improvement was demonstrated through repeated measurements over comparable time periods. While the MCO demonstrated sustained improvement in PI 1 and PI2, which are provider survey response measures, PI3 and PI4, which are outcome indicators, did not show improvement.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed most of the recommendations provided for the 2022 PIP submission. However, the MCO should remove the example at the top of Table 1a on page 17, as directed last year. Additionally, it was noted on page 21, Yr. 1 ITMs 1a and 1b writing convention should be updated to 0/0=NA for the Final Report submission August 2024. The MCO updated interventions during the past measurement year. The MCO should review all sections of the PIP for a complete and comprehensive evaluation in the Final Report submission.

FC/WCHP PIP 2: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 2: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**PM**	**M**		
Element 3 Overall Score	**N/A**	**50**	**100**	0	0
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M		
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M		
4f. Literature review	**N/A**	M	M		
Element 4 Overall Review Determination	**N/A**	**M**	**M**		
Element 4 Overall Score	**N/A**	**100**	**100**	0	0
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	PM		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M		
Element 5 Overall Review Determination	**N/A**	**PM**	**PM**		
Element 5 Overall Score	**N/A**	**50**	**50**	**0**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**7.5**	**0.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	PM	M		
Element 6 Overall Review Determination	**N/A**	**PM**	**M**		
Element 6 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**0.0**	**0.0**

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	PM		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes N=No)	**N/A**	**Y**	**Y**		

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**62.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**75.0%**	**78.1%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: September 21, 2023
Report Status: Year 2

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant regarding element 5a, robust interventions informed by barrier analysis. On pages 45-46, the MCO lists a number of barriers, however, the MCO has not provided interventions to address these barriers. Additionally, the MCO should review the fishbone diagram for potential active interventions to remedy the barriers noted.

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

Element 7 Overall Review Determination was that the MCO is partially compliant regarding element 7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity. On page 45, the MCO notes that "It has been discovered from immunization data analysis that there are possible data integrity issues in capturing vaccines records due to potential providers submitting deprecated procedure codes and/or the State vaccination registry utilizing deprecated procedure codes. (i.e., Hep B 90731)", however, the MCO does not address this as a factor affecting external validity and has not implemented interventions to correct the issue.

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

Element 9 Overall Review Determination was that Healthcare disparities have been reviewed and are being addressed.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 62.5 points, which results in a rating of 78.1% (Which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed the issues identified in Year 1, including updating the baseline and addressing potential provider-related barriers. While sustained improvement is not scored in Year 2, the MCO should address the decline in performance for the two PIs with modified or new interventions that are reflected in the Interventions table.

FC/WCHP PIP 3: Core Medicaid Complaints and Grievances

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 3: Core Medicaid Complaints and Grievances

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

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

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

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

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org), Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: December 13, 2023
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, the Aim Statement should be consistent with the actual performance indicator, the number of Medicaid grievances per 1,000 members (as opposed to simply a reduction in member balance billing grievances).

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A.

Element 5 Overall Review Determination was N/A.

Element 6 Overall Review Determination was N/A.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination: Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities in this PIP.

For this submission, this PIP Proposal was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address the issue above with revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on performance indicators.

FC/WCHP PIP 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**70.0**	**65.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**87.5%**	**81.3%**	**0.0%**	**0.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan).

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (LHeffernan@ipro.org)
Date (report submission) reviewed: October 6, 2023
Reporting Period: Year 2

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

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

Element 3 Overall Review Determination was that the MCO is partially compliant, regarding element 3d, Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined. For Indicator 1, 30-day follow up after inpatient discharge for behavioral health diagnosis, the MCO notes an exclusion of

members who transition to an assisted living facility post-acute inpatient discharge. Per HEDIS specifications, exclusions appear to be limited to acute and non-acute inpatient. The MCO should clarify and justify the use of this assisted living facility exclusion.

Element 4 Overall Review Determination was that the MCO is partially compliant regarding element 4d, QI Process data ("5 Why's", fishbone diagram). The MCO noted a number of barriers in the August 2023 update, however the Fishbone Diagram (pg.46) was not updated to reflect each barrier identified. The MCO should review the identified barriers, document potential interventions that may overcome these barriers and what interventions the MCO might address.

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

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

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

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

Element 9 Overall Review Determination was that Healthcare disparities have been assessed and are being addressed through identification of SDOH and appropriate referrals.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 65.0 points, which results in a rating of 81.3% (Which is below 86% [≥ 86% being the threshold for meeting compliance]). In review of the Results Table, pg. 32, PI #1 exhibits a significant decrease from Y1 to Y2 (preliminary data), noting a slight increase in Y2. The MCO's is focusing on provider training, which is important, but limited participation has been noted. The MCO should continue to pursue improvement in provider communication on appropriate follow-up treatment. A number of additional barriers were noted in 2023, including lack of timely notification of BH admissions, rapid readmissions for certain members, and difficulty obtaining FFS follow-up visit data. The MCO should address these barriers specifically in the interventions.

FC/WCHP – HEDIS Audit Review Table MY 2022

Audit Review Table					
WellCare Health Plans of New Jersey, Inc. (Org ID: 10793, Sub ID: 11953, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2022; Date & Timestamp - 6/14/2023 5:53:02 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		83.21%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		80.05%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		79.08%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		66.42%	R	R	Reported
Childhood Immunization Status - IPV		82.00%	R	R	Reported
Childhood Immunization Status - MMR		84.43%	R	R	Reported
Childhood Immunization Status - HiB		82.00%	R	R	Reported
Childhood Immunization Status - Hepatitis B		77.62%	R	R	Reported
Childhood Immunization Status - VZV		83.70%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		64.72%	R	R	Reported
Childhood Immunization Status - Hepatitis A		73.72%	R	R	Reported
Childhood Immunization Status - Rotavirus		60.58%	R	R	Reported
Childhood Immunization Status - Influenza		45.99%	R	R	Reported
Childhood Immunization Status - Combo 3		56.45%	R	R	Reported
Childhood Immunization Status - Combo 7		44.53%	R	R	Reported
Childhood Immunization Status - Combo 10		31.87%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		83.70%	R	R	Reported
Immunizations for Adolescents - Tdap		87.10%	R	R	Reported
Immunizations for Adolescents - HPV		30.66%	R	R	Reported
Immunizations for Adolescents - Combination 1		82.48%	R	R	Reported
Immunizations for Adolescents - Combination 2		28.47%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		72.02%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		57.71%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		50.12%	R	R	Reported
Colorectal Cancer Screening (COL)					

Colorectal Cancer Screening (Total)		32.38%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		67.23%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		59.35%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		30.83%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		68.25%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		88.36%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		60.23%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		65.45%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		65.31%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		79.17%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		71.95%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		1.14%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		2.29%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		4.00%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		1.14%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)		56.69%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control		34.55%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		66.67%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		47.69%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		38.08%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		73.66%	R	R	Reported

Statin Therapy for Patients With Diabetes - Statin Adherence 80%		61.68%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
Diagnosed Mental Health Disorders (Total)		19.44%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		57.92%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		42.79%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		40.28%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		50.00%	NA	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		34.38%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		20.47%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		59.17%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		51.00%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Diagnosed Substance Use Disorders - Alcohol (Total)		2.82%	R	R	Reported
Diagnosed Substance Use Disorders - Opioid (Total)		3.41%	R	R	Reported
Diagnosed Substance Use Disorders - Other (Total)		3.63%	R	R	Reported
Diagnosed Substance Use Disorders - Any (Total)		6.86%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		48.01%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		27.06%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)		33.92%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)		24.51%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		22.92%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		89.02%	R	R	Reported

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		76.34%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		77.27%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		70.12%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		59.72%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		49.31%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		47.92%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.10%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		85.96%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		50.37%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain (Total)		79.85%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		6.61%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		11.54%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.56%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.87%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		8.97%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.64%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		71.82%	R	R	Reported
Annual Dental Visit (ADV)	Y				

Annual Dental Visit (Total)		51.44%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total (Total)		44.28%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment - Total (Total)		11.11%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		79.81%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		78.83%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		68.75%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		44.73%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		67.12%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		55.97%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
Antibiotic Utilization for Respiratory Conditions (Total)		18.90%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
Childhood Immunization Status - DTaP		55.87%	R	R	Reported
Childhood Immunization Status - IPV		69.33%	R	R	Reported
Childhood Immunization Status - MMR		81.06%	R	R	Reported
Childhood Immunization Status - HiB		72.66%	R	R	Reported
Childhood Immunization Status - Hepatitis B		27.40%	R	R	Reported
Childhood Immunization Status - VZV		79.75%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		54.38%	R	R	Reported
Childhood Immunization Status - Hepatitis A		71.77%	R	R	Reported
Childhood Immunization Status - Rotavirus		52.71%	R	R	Reported
Childhood Immunization Status - Influenza		40.98%	R	R	Reported

Childhood Immunization Status - Combo 3		19.83%	R	R	Reported
Childhood Immunization Status - Combo 7		16.44%	R	R	Reported
Childhood Immunization Status - Combo 10		9.71%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Immunizations for Adolescents - Meningococcal		81.70%	R	R	Reported
Immunizations for Adolescents - Tdap		84.94%	R	R	Reported
Immunizations for Adolescents - HPV		29.90%	R	R	Reported
Immunizations for Adolescents - Combination 1		80.26%	R	R	Reported
Immunizations for Adolescents - Combination 2		28.24%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		57.60%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
Colorectal Cancer Screening (Total)		31.94%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		40.28%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		50.00%	NA	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		59.72%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		49.31%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		47.92%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0.00%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.00%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					

Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza (19-65)		14.49%	R	R	Reported
Adult Immunization Status - Td/Tdap (19-65)		18.67%	R	R	Reported
Adult Immunization Status - Zoster (50-65)		3.53%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		16.94%	R	R	Reported
Prenatal Immunization Status - Tdap		29.72%	R	R	Reported
Prenatal Immunization Status - Combination		10.04%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2023 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	23	7	0	23	77%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access	14	4	10	7	3	0	11	79%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	11	1	0	20	95%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment[5]	29	0	29	27	2	0	27	93%
Credentialing and Recredentialing	10	7	3	3	0	0	10	100%
Utilization Management	30	16	14	13	1	0	29	97%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**228**	**113**	**115**	**108**	**7**	**0**	**221**	**97%**

[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.

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

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

[5] Member Disenrollment is a new standard reviewed in 2023.

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

HNJH Performance Improvement Projects

HNJH PIP 1: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits

MCO Name: Horizon New Jersey Health (HNJH)

PIP Topic 1: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits

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

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	M	N/A	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	
5b. Actions that target member, provider and MCO	N/A	M	M	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M	PM	
Element 5 Overall Review Determination	**N/A**	**PM**	**M**	**PM**	
Element 5 Overall Score	**N/A**	**50**	**100**	**50**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**15.0**	**7.5**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					

6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes N=No)	**N/A**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**70.0**	**92.5**	**0.0**
Overall Rating	**N/A**	**81.3%**	**87.5%**	**92.5%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 2, 2023
Reporting Period: Year 3

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant regarding element 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). Miscalculations were noted on page 28, Yr.2 Q4, ITM 2b, 493/875 does not equal 56.36%. On page 30, Yr. 2 Q3, ITM 2b, 400/1,055 does not equal 37.56%, and on page 32, Yr. 2, PI # 3 276/268 does not equal 58.97%. The MCO should ensure that all calculations are reviewed for accuracy for the final report submission in August 2024.

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that healthcare disparity was evaluated through analysis of ED utilization by race/ethnicity, gender and age (p. 35, Table 3). While an analysis was completed, disparities were not specifically addressed in the discussion or interventions.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 92.5 points, which results in a rating of 92.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed calculation and rounding issues identified in the prior submission. The MCO presented an in-depth analysis of interventions by provider practice and their potential impact on results. The MCO should ensure that data analysis adheres to the data analysis plan the MCO presented and that 2023 data are addressed. Additionally, the MCO might consider expanding on the definition of the Pearson Chi-Square Test of Proportions that would be compared for baseline and final measurement groups, for reader clarity and understanding.

HNJH PIP 2: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 2: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	PM		
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M		
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M		
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M		
Element 7 Overall Review Determination	**N/A**	**M**	**PM**		
Element 7 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**0.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A		
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A		
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**		
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**0**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**0.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes N=No)	**N/A**	**Y**	**Y**		

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

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: September 21, 2023
Reporting Period: Year 2

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

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

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

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

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

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

Element 7 Overall Review Determination was that the MCO is partially compliant regarding Element 7a, Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions). On pg. 22, Results Table 2, the MCO documents an exceptionally significant increase in PI 1 in Y1, (898/1349=66.57% from the Baseline of 14.51%) although PI 3 exhibits a slight increase Y1, (632/2150=29.40%) from the Baseline of 29.40%. The MCO has not provided an explanation of the variance between these 2 PIs as the only difference appears to be PI 1 the percent of members 30 months of age or younger... at their assigned PCP offices versus the percent of members turning 24 months of age... that received all Combo 10 immunizations by the end of the HEDIS measurement year. Additionally, the MCO should include interim data available for Year 2 January - June 2023.

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

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

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 70.0 points, which results in a rating of 87.5% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). Healthcare disparities were addressed with an analysis by geographic area (urban vs. rural) and race. In Section 4, under Methodology, pages 12-14, the MCO notes data sources as hybrid and administrative claims, however, if hybrid data were used, the MCO should have addressed sampling. For PI 1, page 11 the MCO noted that for CIS10 measures members 30 months or younger, while HEDIS specifications for CIS10 is typically measured for members 24 months or younger. The MCO should clarify the difference/variance between 24 months (CIS 10 Combo) and the 30 months for W30 measure for clarity and understanding of the reader. Additionally, the MCO should ensure that pages 1 and 2 should be combined to illustrate the full Title Page of the PIP.

HNJH PIP 3: Complaints and Grievances - Core Medicaid Membership

MCO Name: Horizon New Jersey Health (HNJH)
PIP Topic 3: Complaints and Grievances - Core Medicaid Membership

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

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

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

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

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org), Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) reviewed: October 27, 2023
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, the MCO can use 2022 grievance data as a reference/resource but should update the Baseline Year and data to 2023, including the full year of baseline data in the April submission. The MCO should also ensure the Baseline year 2023 is noted in the Goals table on page 9.

Element 3 Overall Review Determination was N/A. Although not scored, the MCO should consider updating the Performance Indicators on pages 10 and 11 from percentages of grievances to number of grievances in each category per 1,000 members. If using percentage of grievances, the denominator period over period will change. This could lead to invalid and inaccurate assessment of improvement or decline in the measure. For example, if balance billing grievances make up 100 out of 200 grievances, the percentage would be 50%. If, in the next period, there were 100 out of 350 grievances, the percentage would be 28.5%. This would suggest false improvement in the indicator, as the actual number of grievances did not decrease over time. The MCO should review and adjust accordingly for consistent data flow and validity over the life of the PIP.

Element 4 Overall Review Determination was N/A. Although not scored, the barrier analysis (fishbone diagram) was well-developed.

Element 5 Overall Review Determination was N/A. Although not scored, the interventions planned on pages 14 and 15 do not address several barriers noted in the fishbone diagram. Member educational interventions, specific education and corrective action for providers with high levels of complaints in the areas under review, and MCO interventions (i.e. Customer Service education and member counseling) should be considered.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. The MCO should update the year on the Title page to 2024, the year of initiation of the PIP. The MCO should combine pages 1 and 2 for the Title page and delete the example in the Change Table on page 3. The MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the Performance Indicators.

HNJH PIP 4: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 4: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**100.0%**	**0.0%**	**0.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 6, 2023
Reporting Period: Year 2

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

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

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

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

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

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

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

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

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on race/ethnicity.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has implemented a number of care management-related interventions, which have appeared to positively impact follow-up visit within 30-day rates (PI3). Also, there has been significant improvement for PI1, well visits for members with behavioral health diagnoses. PI4, behavioral health readmissions, however, have increased over baseline. The MCO should further evaluate readmission activity to develop appropriate interventions. The MCO should ensure all relevant information is included in the title page (refer to pages 1 and 2). Also, on page 25, a miscalculation was identified in Y1 Q2 of 2022, 671/3869 was noted as 17.64%. The MCO should review the calculation and update for the next submission.

HNJH – HEDIS Audit Review Table MY 2022

Audit Review Table					
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health (Org ID: 6610, Sub ID: 7459, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2022; Date & Timestamp - 6/5/2023 2:29:22 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		83.51%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		79.57%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		76.70%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		71.53%	R	R	Reported
Childhood Immunization Status - IPV		88.32%	R	R	Reported
Childhood Immunization Status - MMR		86.37%	R	R	Reported
Childhood Immunization Status - HiB		88.32%	R	R	Reported
Childhood Immunization Status - Hepatitis B		87.59%	R	R	Reported
Childhood Immunization Status - VZV		84.91%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		71.78%	R	R	Reported
Childhood Immunization Status - Hepatitis A		78.10%	R	R	Reported
Childhood Immunization Status - Rotavirus		71.29%	R	R	Reported
Childhood Immunization Status - Influenza		52.31%	R	R	Reported
Childhood Immunization Status - Combo 3		63.75%	R	R	Reported
Childhood Immunization Status - Combo 7		51.82%	R	R	Reported
Childhood Immunization Status - Combo 10		35.52%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		91.48%	R	R	Reported
Immunizations for Adolescents - Tdap		93.43%	R	R	Reported
Immunizations for Adolescents - HPV		36.01%	R	R	Reported
Immunizations for Adolescents - Combination 1		90.75%	R	R	Reported
Immunizations for Adolescents - Combination 2		34.31%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		68.09%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		57.51%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		59.55%	R	R	Reported
Colorectal Cancer Screening (COL)					

Colorectal Cancer Screening (Total)		39.33%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		60.24%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		55.59%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		30.57%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		71.49%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		87.39%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		74.73%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		65.72%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		84.12%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		81.66%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		75.98%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		1.45%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		2.89%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		3.52%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		0.88%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)		59.41%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control		34.96%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		63.33%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		55.99%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		33.53%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Statin Therapy for Patients With Diabetes - Received Statin Therapy		69.09%	R	R	Reported

Statin Therapy for Patients With Diabetes - Statin Adherence 80%		68.10%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
Diagnosed Mental Health Disorders (Total)		24.28%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		59.16%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		44.32%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		31.34%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		35.74%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		53.95%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		30.23%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		66.86%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		58.09%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Diagnosed Substance Use Disorders - Alcohol (Total)		2.71%	R	R	Reported
Diagnosed Substance Use Disorders - Opioid (Total)		3.64%	R	R	Reported
Diagnosed Substance Use Disorders - Other (Total)		3.45%	R	R	Reported
Diagnosed Substance Use Disorders - Any (Total)		7.26%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		52.49%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		31.47%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)		42.17%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)		31.05%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		28.37%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		80.01%	R	R	Reported

Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		66.41%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		78.57%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		67.99%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		44.17%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		37.38%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		29.65%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.21%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		87.32%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		52.31%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain (Total)		74.62%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		11.59%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		17.59%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.79%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.77%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		5.77%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		3.53%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Adults' Access to Preventive/Ambulatory Health Services (Total)		79.51%	R	R	Reported
Annual Dental Visit (ADV)	Y				

Annual Dental Visit (Total)		59.13%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total (Total)		39.56%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment - Total (Total)		9.79%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		79.63%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		78.89%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		69.13%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		55.38%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		71.53%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		60.28%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
Antibiotic Utilization for Respiratory Conditions (Total)		17.22%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
Childhood Immunization Status - DTaP		61.71%	R	R	Reported
Childhood Immunization Status - IPV		77.52%	R	R	Reported
Childhood Immunization Status - MMR		82.74%	R	R	Reported
Childhood Immunization Status - HiB		79.57%	R	R	Reported
Childhood Immunization Status - Hepatitis B		68.34%	R	R	Reported
Childhood Immunization Status - VZV		81.90%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		59.25%	R	R	Reported
Childhood Immunization Status - Hepatitis A		74.14%	R	R	Reported
Childhood Immunization Status - Rotavirus		60.41%	R	R	Reported
Childhood Immunization Status - Influenza		44.38%	R	R	Reported

Childhood Immunization Status - Combo 3		45.67%	R	R	Reported
Childhood Immunization Status - Combo 7		37.38%	R	R	Reported
Childhood Immunization Status - Combo 10		23.36%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Immunizations for Adolescents - Meningococcal		88.52%	R	R	Reported
Immunizations for Adolescents - Tdap		90.55%	R	R	Reported
Immunizations for Adolescents - HPV		34.01%	R	R	Reported
Immunizations for Adolescents - Combination 1		87.54%	R	R	Reported
Immunizations for Adolescents - Combination 2		32.57%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		57.39%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
Colorectal Cancer Screening (Total)		38.81%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		31.34%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		35.74%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		44.17%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		37.38%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		29.65%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0.00%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)			NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.00%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)			NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					

Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza (19-65)		8.68%	R	R	Reported
Adult Immunization Status - Td/Tdap (19-65)		16.54%	R	R	Reported
Adult Immunization Status - Zoster (50-65)		2.10%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		18.61%	R	R	Reported
Prenatal Immunization Status - Tdap		37.31%	R	R	Reported
Prenatal Immunization Status - Combination		12.76%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0.00%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2023 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	24	6	0	24	80%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access	14	4	10	6	4	0	10	71%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	11	1	0	20	95%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	32	12	12	0	0	44	100%
Provider Training and Performance	11	6	5	5	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment[5]	29	0	29	29	0	0	29	100%
Credentialing and Re-credentialing	10	8	2	2	0	0	10	100%
Utilization Management	30	16	14	12	0	2	28	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**228**	**112**	**116**	**109**	**5**	**2**	**221**	**97%**

[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.
[3] Elements that were *Met* in this review period among those that were subject to review as well as elements that were *Met* in the previous review period and were not subject to review (i.e., were deemed *Met*). This total is used to calculate the compliance score for each standard as well as the overall compliance score.
[4] The compliance score is calculated as the number of *Total Met* elements over the number of applicable elements. The denominator is the number of total elements minus *N/A* elements. The numerator is the number of *Total Met* elements.
[5] Member Disenrollment is a new standard reviewed in 2023.
*The Core Medicaid and MLTSS Care Management and Continuity of Care elements were not included in the Annual Assessment scoring as the MCOs were reviewed and scored in separate reports and each MCO submitted Corrective Action Plans (CAPs) as applicable.

UHCCP Performance Improvement Projects

UHCCP PIP 1: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 1: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members

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

3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	M	M	M	
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	M	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	
5b. Actions that target member, provider and MCO	N/A	M	M	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	M	
Element 5 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 5 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	M	M	M	
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	

Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**0.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	PM	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**PM**	
Element 7 Overall Score	**N/A**	**100**	**100**	**50**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**10.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (**Y**=Yes **N**=No)	**N**	**N**	**N**	**N**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**77.5**	**80.0**	**90.0**	**0.0**
Overall Rating	**0%**	**96.9%**	**100%**	**90.0%**	**0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org); Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 3, 2023
Reporting Period: Year 3

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

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

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

Element 4 Overall Review Determination was that the MCO is compliant.
Element 5 Overall Review Determination was that the MCO is compliant.

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

Element 7 Overall Review Determination was that the MCO was partially compliant. Element 7c requires an analysis to identify changes in indicator performance, factors that influence comparability, and that threaten internal/external validity. The MCO noted that internal validity was impacted by duplicate counting of ED visits in 2021 which has been evaluated and updated. On pg. 66, the MCO documented eight (8) additional diagnoses which were added after review of 2022 ED claims in Quarter 4. However, the impact of adding LANE diagnoses for identifying ED visits as of Q4 2022 was not addressed. The MCO should include the data related to newly added diagnoses for Q1 2023 and Q2 2023, although it may be interim data. In the Sustainability Year reporting the data for quarters 1 and 2 are potential indicators of progress toward the long-term goals and sustainability.

Element 8 Overall Review Determination was that the MCO is compliant**.**

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 90 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO presented an in-depth analysis of interventions by provider practice and their potential impact on results. The MCO should ensure that factors affecting validity are all addressed, 2023 data included, and all sections are reviewed for a complete and comprehensive evaluation in the Final Report submission.

UHCCP PIP 2: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 2: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**80.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**100.0%**	**0.0%**	**0.0%**

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

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: September 21, 2023
Reporting Period: Year 2

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

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

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

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

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

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

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

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

Element 9 Overall Review Determination was that the MCO identified health care disparities and is prioritizing interventions based on the analysis.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 80.0 points, which results in a rating of 100.0% (Which is above 85% [≥ 85% being the threshold for meeting compliance]). While the MCO did not see consistent improvement in PI rates over year 1, they did provide a comprehensive analysis of factors affecting success of interventions and reasons to anticipate improvement in Year 2. The MCO should consider including preliminary 2023 results in the Results table to strengthen the analysis.

UHCCP PIP 3: Reducing Member Grievances for Medicaid Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 3: Reducing Member Grievances for Medicaid Members

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

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

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

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

[1]MCOs are at the proposal stage for this PIP and will be scored in MY 1.

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org); Donna Reinholdt (dreinholdt@ipro.org)
Date (report submission) Reviewed: October 27, 2023
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, under Project Topic, the MCO does not address the high-volume situation addressed by the PIP. In addition, the MCO did not explain why there is an opportunity for improvement in this area. The MCO should consider updating these items in the next submission.

Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A. Although not scored, the MCO should consider updating the Performance Indicators on pages 9 and 10 from percentages of grievances to number of grievances in each category per 1,000 members. If using percentage of grievances, the denominator period over period will change. This could lead to invalid and inaccurate assessment of improvement or decline in the measure. For example, if balance billing grievances make up 100 out of 200 grievances, the percentage would be 50%. If, in the next period, there were 100 out of 350 grievances, the percentage would be 28.5%. This would suggest a false improvement in the indicator, as the actual number of grievances did not decrease over time. The MCO should review and adjust accordingly for consistent data flow and validity over the life of the PIP.

Element 5 Overall Review Determination was N/A. Although not scored, the MCO did not address interventions for out-of-network balance billing and improving member understanding of balance billing requirements on pages 12 and 13. The MCO should update accordingly in the next submission.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO did not plan to identify, evaluate, and address healthcare disparities in this PIP.

For this submission, this PIP Proposal was not scored. Therefore, the rating for the PIP for overall compliance is N/A. Although not scored, the MCO should update the year on the Title page to 2024, the year of initiation of the PIP. The MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on Performance Indicators.

UHCCP PIP 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 4: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A		
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M		
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M		
Element 3 Overall Review Determination	**N/A**	**M**	**M**		
Element 3 Overall Score	**N/A**	**100**	**100**	0	0
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**0.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M		
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M		
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M		
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M		
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M		
4f. Literature review	N/A	M	M		
Element 4 Overall Review Determination	**N/A**	**PM**	**M**		
Element 4 Overall Score	**N/A**	**50**	**100**	0	0
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M		
5b. Actions that target member, provider and MCO	N/A	M	M		
5c. New or enhanced, starting after baseline year	N/A	M	M		
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M		
Element 5 Overall Review Determination	**N/A**	**PM**	**M**		
Element 5 Overall Score	**N/A**	**50**	**100**	**0**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**15.0**	**0.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	M	PM		
Element 6 Overall Review Determination	**N/A**	M	**PM**		
Element 6 Overall Score	**N/A**	**100**	**50**	**0**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**2.5**	**0.0**	**0.0**

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**77.5**	**0.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**96.9%**	**0.0%**	**0.0%**

≥ 86% met; 60-85% partial met (corrective action plan); <60% not met (corrective action plan)

IPRO Reviewers: Donna Reinholdt (dreinholdt@ipro.org), Lois Heffernan (lheffernan@ipro.org)
Date (report submission) reviewed: October 6, 2023
Reporting Period: Year 2

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

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

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

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

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

Element 6 Overall Review Determination was that the MCO is partially compliant regarding element 6a, Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals. The MCO did not include preliminary 2023 rates, which should be included for ongoing analysis.

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

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

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on race/ethnicity.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 80.0 points the MCO scored 77.5 points, which results in a rating of 96.9% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO updated the barrier analysis and implemented additional interventions to address barriers encountered, The MCO presented a data-driven analysis of results, identifying the increase in MLTSS membership and multiple readmissions for the same members. The MCO should include 2023 preliminary data in the results section.

UHCCP – HEDIS Audit Review Table MY 2022

Audit Review Table					
AmeriChoice of New Jersey, Inc. dba UnitedHealthcare Community Plan (NJ) (Org ID: 1995, Sub ID: 8004, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2022; Date & Timestamp - 6/9/2023 6:12:03 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI percentile (Total)		82.97%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)		76.64%	R	R	Reported
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)		72.02%	R	R	Reported
Childhood Immunization Status (CIS)					
Childhood Immunization Status - DTaP		67.15%	R	R	Reported
Childhood Immunization Status - IPV		81.27%	R	R	Reported
Childhood Immunization Status - MMR		79.81%	R	R	Reported
Childhood Immunization Status - HiB		81.02%	R	R	Reported
Childhood Immunization Status - Hepatitis B		76.40%	R	R	Reported
Childhood Immunization Status - VZV		78.83%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		63.02%	R	R	Reported
Childhood Immunization Status - Hepatitis A		70.56%	R	R	Reported
Childhood Immunization Status - Rotavirus		59.85%	R	R	Reported
Childhood Immunization Status - Influenza		46.72%	R	R	Reported
Childhood Immunization Status - Combo 3		54.99%	R	R	Reported
Childhood Immunization Status - Combo 7		44.53%	R	R	Reported
Childhood Immunization Status - Combo 10		33.33%	R	R	Reported
Immunizations for Adolescents (IMA)					
Immunizations for Adolescents - Meningococcal		86.77%	R	R	Reported
Immunizations for Adolescents - Tdap		89.71%	R	R	Reported
Immunizations for Adolescents - HPV		31.29%	R	R	Reported
Immunizations for Adolescents - Combination 1		85.59%	R	R	Reported
Immunizations for Adolescents - Combination 2		30.08%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		70.80%	R	R	Reported
Breast Cancer Screening (BCS)					
Breast Cancer Screening		60.68%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		59.25%	R	R	Reported

Colorectal Cancer Screening (COL)					
Colorectal Cancer Screening (Total)		46.33%	R	R	Reported
Chlamydia Screening in Women (CHL)					
Chlamydia Screening in Women (Total)		63.05%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
Appropriate Testing for Pharyngitis (Total)		70.96%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		33.44%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid		64.92%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation - Bronchodilator		85.25%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
Asthma Medication Ratio (Total)		60.26%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		67.88%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		80.49%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Statin Therapy for Patients With Cardiovascular Disease - Received Statin Therapy (Total)		79.82%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease - Statin Adherence 80% (Total)		76.14%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (Total)		0.35%	R	R	Reported
Cardiac Rehabilitation - Engagement1 (Total)		3.28%	R	R	Reported
Cardiac Rehabilitation - Engagement2 (Total)		5.01%	R	R	Reported
Cardiac Rehabilitation - Achievement (Total)		2.59%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
Hemoglobin A1c Control for Patients With Diabetes - HbA1c Control (<8%)		61.80%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes - Poor HbA1c Control		28.47%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		72.99%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		62.53%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (Total)		38.20%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				

Statin Therapy for Patients With Diabetes - Received Statin Therapy		72.47%	R	R	Reported
Statin Therapy for Patients With Diabetes - Statin Adherence 80%		72.23%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
Diagnosed Mental Health Disorders (Total)		23.77%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				
Antidepressant Medication Management - Effective Acute Phase Treatment		63.50%	R	R	Reported
Antidepressant Medication Management - Effective Continuation Phase Treatment		46.55%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		39.51%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		42.64%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
Follow-Up After Hospitalization For Mental Illness - 30 days (Total)		49.83%	R	R	Reported
Follow-Up After Hospitalization For Mental Illness - 7 days (Total)		31.36%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
Follow-Up After Emergency Department Visit for Mental Illness - 30 days (Total)		65.77%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total)		57.01%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Diagnosed Substance Use Disorders - Alcohol (Total)		2.23%	R	R	Reported
Diagnosed Substance Use Disorders - Opioid (Total)		2.83%	R	R	Reported
Diagnosed Substance Use Disorders - Other (Total)		3.02%	R	R	Reported
Diagnosed Substance Use Disorders - Any (Total)		5.85%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)		46.47%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)		27.94%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
Follow-Up After Emergency Department Visit for Substance Use - 30 days (Total)		36.64%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)		26.96%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
Pharmacotherapy for Opioid Use Disorder (Total)		24.32%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		87.05%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		75.39%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		82.11%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		70.47%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		59.37%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		43.33%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		41.71%	R	R	Reported
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.18%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
Appropriate Treatment for Upper Respiratory Infection (Total)		85.59%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)		51.17%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
Use of Imaging Studies for Low Back Pain (Total)		77.04%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.12%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Use of Opioids From Multiple Providers - Multiple Prescribers		11.57%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Pharmacies		1.28%	R	R	Reported
Use of Opioids From Multiple Providers - Multiple Prescribers and Multiple Pharmacies		0.71%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
Risk of Continued Opioid Use - >=15 Days (Total)		6.96%	R	R	Reported
Risk of Continued Opioid Use - >=31 Days (Total)		4.56%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					

Adults' Access to Preventive/Ambulatory Health Services (Total)		81.98%	R	R	Reported
Annual Dental Visit (ADV)	Y				
Annual Dental Visit (Total)		64.48%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation and Engagement of Substance Use Disorder Treatment - Initiation of SUD Treatment - Total (Total)		44.66%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment - Engagement of SUD Treatment - Total (Total)		9.14%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Prenatal and Postpartum Care - Timeliness of Prenatal Care		84.18%	R	R	Reported
Prenatal and Postpartum Care - Postpartum Care		80.78%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)		66.27%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 30 Months of Life (First 15 Months)		52.43%	R	R	Reported
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)		69.30%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (Total)		59.08%	R	R	Reported
Frequency of Selected Procedures (FSP)			R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
Antibiotic Utilization for Respiratory Conditions (Total)		18.46%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					
Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
Childhood Immunization Status - DTaP		56.00%	R	R	Reported
Childhood Immunization Status - IPV		72.02%	R	R	Reported
Childhood Immunization Status - MMR		77.81%	R	R	Reported
Childhood Immunization Status - HiB		74.17%	R	R	Reported
Childhood Immunization Status - Hepatitis B		50.26%	R	R	Reported
Childhood Immunization Status - VZV		76.80%	R	R	Reported
Childhood Immunization Status - Pneumococcal Conjugate		53.99%	R	R	Reported
Childhood Immunization Status - Hepatitis A		65.83%	R	R	Reported

Childhood Immunization Status - Rotavirus		51.36%	R	R	Reported
Childhood Immunization Status - Influenza		37.56%	R	R	Reported
Childhood Immunization Status - Combo 3		33.29%	R	R	Reported
Childhood Immunization Status - Combo 7		26.99%	R	R	Reported
Childhood Immunization Status - Combo 10		17.89%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Immunizations for Adolescents - Meningococcal		86.77%	R	R	Reported
Immunizations for Adolescents - Tdap		89.71%	R	R	Reported
Immunizations for Adolescents - HPV		31.29%	R	R	Reported
Immunizations for Adolescents - Combination 1		85.59%	R	R	Reported
Immunizations for Adolescents - Combination 2		30.08%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		60.54%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
Colorectal Cancer Screening (Total)		45.65%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		39.51%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		42.64%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose Testing (Total)		59.37%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Cholesterol Testing (Total)		43.33%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics - Blood Glucose and Cholesterol Testing (Total)		41.71%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening and Follow-Up for Adolescents and Adults - Depression Screening (Total)		0.46%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults - Follow-Up on Positive Screen (Total)		72.73%	NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Utilization of PHQ-9-Total (Total)		0.48%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					
Depression Remission or Response for Adolescents and Adults - Follow-Up PHQ-9 (Total)		0.00%	NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Remission (Total)		0.00%	NA	R	Reported
Depression Remission or Response for Adolescents and Adults - Depression Response (Total)		0.00%	NA	R	Reported

Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening and Follow-Up - Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up - Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Adult Immunization Status - Influenza (19-65)		15.86%	R	R	Reported
Adult Immunization Status - Td/Tdap (19-65)		26.01%	R	R	Reported
Adult Immunization Status - Zoster (50-65)		6.96%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Prenatal Immunization Status - Influenza		17.25%	R	R	Reported
Prenatal Immunization Status - Tdap		30.43%	R	R	Reported
Prenatal Immunization Status - Combination		11.11%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Prenatal Depression Screening and Follow-Up - Depression Screening		0.21%	R	R	Reported
Prenatal Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Postpartum Depression Screening and Follow-Up - Depression Screening		0.02%	R	R	Reported
Postpartum Depression Screening and Follow-Up - Follow-Up on Positive Screen			NA	R	Reported

Appendix B: ABHNJ 2023 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Aetna Better Health of New Jersey

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

November 2023

Corporate Headquarters
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MCO Care Management Chart Audit

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, NJ Care Management Workbook, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology, as shown in Table 1, resulted in the selection of 162 cases for Aetna Better Health of New Jersey (ABHNJ), including a 10% oversample for the General Population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) was selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (15). All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (37).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. AND (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499). Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2022	>= 3 months as of 12/31/2022	>= 3 months and < 18 years as of 12/31/2022
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2022 and 7/1/2022	Initial enrollment between 1/1/2022 and 12/31/2022	Initial enrollment between 1/1/2022 and 12/31/2022
• Existing Enrollees	Enrolled prior to 1/1/2022		
Current Enrollment	Enrolled as of 12/31/2022	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2022 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ 2023 CM Audit results for the review period 1/1/2022 to 12/31/2022 ranged from 56% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=15)	DCP&P (n=17)
Identification[1]	64%		
Outreach	91%	100%	100%
Preventive Services	73%	56%	66%
Continuity of Care	89%	98%	89%
Coordination of Services	96%	100%	100%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 27 Enrollees were New Enrollees, and 73 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	GP Population		
	Numerator	Denominator	Rate
Enrollee has an IHS on file completed during the audit period (1/1/22 to 12/31/22) (applies to New Enrollees only)*	10	27	37.0%
IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only)	3	10	30.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS)*	0	17	0.0%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only)	10	17	58.8%
Enrollees identified by the Plan as having potential Care Management needs (applies to New Enrollees only where IHS score is less than 5 or no IHS on file)*	13	19[1]	68.4%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to New Enrollees only)	1	6	83.3%[2]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2021 or existing Enrollees newly enrolled in CM during the review period)*	16	73	21.9%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2021)	17	57	70.2%[2]
Enrollees identified by the Plan as having potential Care Management needs (applies to Existing Enrollees not enrolled in Care Management prior to 11/16/2021 or during the review period).*	32	40	80.0%

**Not Included in aggregate score calculation*

[1]Denominator includes 17 (seventeen) cases with no IHS on file and 2 (two) cases with an IHS score less than 5

[2] Percentage rate is indicative of an inverse percentage – higher score is indicative of positive performance

Outreach

This section applies only to Existing Enrollees not in Care Management prior to 11/16/21 where the MCO identified need, and to New Enrollees where the MCO identified need based on an IHS score greater than or equal to 5, or through other means where no IHS was on file or the IHS score was less than 5.

Table 4: Outreach – GP Population

Outreach	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	55	100	55.0%
The MCO completed a CNA during the audit period*	6	55	10.9%
For Enrollees with no CNA on file, initial outreach to complete a CNA was done	42	49	85.7%
For Enrollees with no CNA on file, the outreach for CNA was timely within 30 days of the identification of CM needs	41	42	97.6%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	19	42	45.2%
Aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	40	42	95.2%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	40	40	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	18	19	94.7%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	18	19	94.7%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees in Care Management during the review period. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. ABHNJ had a total of 15 cases in the General Population who were in Care Management during the review period.

Table 5: Preventive Services – GP Population

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	1	2	50.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	1	2	50.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	1	1	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	4	13	30.8%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	8	9	88.9%
Dental needs are addressed for Enrollees (aged 21 and above)	13	13	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	0	2	0.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	2	2	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	2	2	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	1	2	50.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	1	1	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	2	2	100.0%

**Not Included in aggregate score calculation*

Continuity of Care

This section includes Enrollees in Care Management during the review period (15). Nine (9) cases were in Care Management prior to 11/16/21. Six (6) cases (4 New Enrollees and 2 Existing Enrollees) were new to Care Management during the review period. Community Based Care Management is reported based on files received from the MCO.

Table 6: Continuity of Care – GP Population

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	55	100	55.0%
The MCO completed a CNA during the audit period*	6	55	10.9%
For the Enrollees that completed a CNA during the audit period, the completed CNA contained all elements of the State approved CNA tool	6	6	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file	3	4	75.0%
A level of Care Management was determined for the Enrollee	6	6	100.0%
The Enrollee is in Community Based Care Management (CBCM). Does not include Enrollees who declined Care Management*	0	15	0.0%

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
A Care Plan was completed for the Enrollee that included all required components	15	15	100.0%
The Care Plan was developed within 30 days of CNA completion	6	6	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances or, for Existing Enrollees with no identified change in needs, Care Plan was monitored.	12	14	85.7%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	3	0.0%

**Not Included in aggregate score calculation*

Coordination of Services

This section includes Enrollees in Care Management during the review period (15). Nine (9) cases were in Care Management prior to 11/16/21. Six (6) cases (4 New Enrollees and 2 Existing Enrollees) were new to Case Management during the review period.

Table 7: Coordination of Services – GP Population

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	15	15	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	12	12	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	12	12	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	7	9	77.8%

DDD Population Findings

A total of 15 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	7	15	46.7%
Initial outreach to complete a CNA was done	15	15	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	8	8	100.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	4	8	50.0%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	5	8	62.5%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	5	5	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	4	4	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	4	4	100.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DDD Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. ABHNJ had a total of 15 cases in the DDD Population.

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	2	5	40.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	3	3	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	3	33.3%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	0	2	0.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	2	2	100.0%

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	1	13	7.7%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	11	12	91.7%
Dental needs are addressed for Enrollees (aged 21 and above)	9	10	90.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	1	5	20.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	4	4	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	2	4	50.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	1	1	100.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	0	1	0.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DDD Members (15).

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	7	15	46.7%
The completed CNA contained all elements of the State approved CNA tool	7	7	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	7	7	100.0%
A level of Care Management was determined for the Enrollee	7	7	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	0	15	0.0%
A Care Plan was completed for the Enrollee that included all required components	14	15	93.3%
The Care Plan was developed within 30 days of CNA Completion	7	7	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	2	2	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	NA[2]

**Not Included in aggregate score calculation*
[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA
[2]NA: Not Applicable

Coordination of Services

This section applies to all DDD Members (15).

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	15	15	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	8	8	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	6	6	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	0	0	NA[1]
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2022 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	NA[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	NA[1]

[1]NA: Not Applicable

DCP&P Population Findings

A total of 37 files were reviewed for the DCP&P Population. (20) files were excluded from the DCP&P Population and were not subject to further review in the following categories. ABHNJ had a total of 17 cases in the DCP&P Population.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	13	17	76.5%
Initial outreach to complete a CNA was done	17	17	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	4	4	100.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	1	4	25.0%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	4	4	100.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	4	4	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	1	0.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	0	1	0.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DCP&P Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. ABHNJ had a total of 17 cases in the DCP&P Population.

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	11	17	64.7%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	6	6	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	2	6	33.3%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	12	17	70.6%

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	5	5	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	0	0	NA[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	0	0	NA[1]
Dental needs are addressed for Enrollees (aged 21 and above)			
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	4	12	33.3%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	8	8	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	5	8	62.5%
For Enrollees aged 9 months to 72 months the Enrollee file contained lead history*	2	3	66.7%
Care Manager made attempts to obtain lead status for Enrollees aged 9 months to 72 months	1	1	100.0%
Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months	1	3	33.3%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DCP&P Members (17).

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	13	17	76.5%
The completed CNA contained all elements of the State approved CNA tool	13	13	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	10	13	76.9%
A level of Care Management was determined for the Enrollee	13	13	100.0%
A Care Plan was completed for the Enrollee that included all required components	13	17	76.5%
The Care Plan was developed within 30 days of CNA Completion	13	13	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	2	3	66.7%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	NA[2]

**Not Included in aggregate score calculation*
[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA
[2]NA: Not Applicable

Coordination of Services

This section applies to all DCP&P Members (17).

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	17	17	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	4	4	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	5	5	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%

Limitations

Audit results for the DDD and DCP&P Populations should be considered cautiously due to the low sample size of 15 and 17 respectively.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (91%)
- Continuity of Care (General Population) (89%)
- Coordination of Services (General Population) (96%)

- Outreach (DDD Population) (100%)
- Continuity of Care (DDD Population) (98%)
- Coordination of Services (DDD Population) (100%)

- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (89%)
- Coordination of Services (DCP&P Population) (100%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (64%)
- Preventive Services (General Population) (73%)

- Preventive Services (DDD Population) (56%)

- Preventive Services (DCP&P Population) (66%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Aetna Better Health of New Jersey, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key ABHNJ staff via WebEx held on May 9, 2023; and post audit evaluation of documentation and audit activities.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the audit review was requested by IPRO on February 10, 2023, and documentation was received from the MCOs on February 27, 2023. The documentation review occurred offsite at IPRO beginning on February 28, 2023. The audit review team was made up of Carla Zuccarello, Sue Williams, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2022 to December 31, 2022.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. ABHNJ received an overall compliance score of 70% in 2023. In 2022, the MCO received a score of 80%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2023. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	-	-	X	-	X	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	X	-	X	-	-	-	X
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	-	X	-	-	-	X
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	-	X	-	-	-	X
CM16	X	X	-	-	-	-	-
CM17	X	-	X	-	-	-	X
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM19	-	X	-	-	-	X	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	24	21	9	0	5	1	4
Compliance Percentage		70%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 77.8% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 83.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees only). 70.2% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 30.0% - IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only).

Element	Contract Language	Reviewer Comments
	(6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	58.8% - When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only).
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2023 CM file audit the MCO scored for the General Population:** 75.0% - The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 76.9% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that	**In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 76.5% - A Care Plan was completed for the Enrollee that included all required components.

Element	Contract Language	Reviewer Comments
	Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires, and level of self-direction of the Enrollee and/or caregiver.	**In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 66.7% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 50.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 50.0% - The Enrollee's immunizations are up to date for Enrollees aged 0 through 18 and immunization status is confirmed by a reliable source. 30.8% - Appropriate vaccines have been administered for Enrollees aged 19 and above. 0.0% - A dental visit occurred during the review period for Enrollees aged 1 through 20. **In the 2023 CM file audit the MCO scored for the DDD Population Enrollees:** 40.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 33.3% - The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).

Element	Contract Language	Reviewer Comments
		0.0% - The Enrollee's immunizations are up to date for Enrollees aged 0 through 18 and immunization status is confirmed by a reliable source. 7.7% - Appropriate vaccines have been administered for Enrollees aged 19 and above. 20.0% - A dental visit occurred during the review period for Enrollees aged 1 through 20. 50.0% - Dental reminders were sent to Enrollees aged 1 through 20. 0.0% - The Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. **In the 2023 CM file audit the MCO scored for the DCP&P Population Enrollees:** 64.7% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 33.3% - The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20). 70.6% - The Enrollee's immunizations are up to date for Enrollees aged 0 through 18 and immunization status is confirmed by a reliable source. 33.3% - A dental visit occurred during the review period for Enrollees aged 1 through 20. 62.5% - Dental reminders were sent to Enrollees aged 1 through 20. 33.3% - Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months.

Element	Contract Language	Reviewer Comments
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 0.0% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs.
CM17	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 0.0% - For Enrollees with a treatment plan, the treatment plan progressed timely.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.

Recommendations

For the General Population:

1. **CM2:** ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed.
2. **CM3**: For New and Existing Enrollees, ABHNJ should ensure that they appropriately identify Enrollees with potential CM needs.
3. **CM6:** ABHNJ should ensure that the IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only), and when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only).
4. **CM7:** ABHNJ should ensure the Comprehensive Needs Assessment is completed timely, within 30 days following an IHS score of 5 or greater.
5. **CM14**: ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source.
6. **CM14**: ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and status is confirmed by a reliable source.
7. **CM14**: ABHNJ should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above).

8. **CM14**: ABHNJ should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20).
9. **CM15:** ABHNJ should ensure that for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.
10. **CM17:** For Enrollees who are given a treatment plan**,** ABHNJ should ensure that the treatment plan progresses in a timely manner without unreasonable interruption.

For the DDD Population:

1. **CM14:** ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sent EPSDT reminders.
2. **CM14:** ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source.
3. **CM14**: ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees (aged 19 and above).
4. **CM14:** For Enrollees (aged 1 through 20), ABHNJ should ensure that a dental visit occurs during the review period, and dental reminders are sent.
5. **CM14:** ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).

For the DCP&P Population:

1. **CM7**: ABHNJ should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM8**: ABHNJ should ensure the Enrollee's completed Care Plan includes all required components.
3. **CM11**: ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.
4. **CM14**: ABHNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sends EPSDT reminders.
5. **CM14**: ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source.
6. **CM14:** For Enrollees (aged 1 through 20), ABHNJ should ensure a dental visit occurs during the review period and dental reminders are sent.
7. **CM14**: ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).

IPRO
Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Aetna Better Health of New Jersey

Review Period July 1, 2022 – June 30, 2023

February 2024

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Better healthcare, realized.

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following State guidance, Managed Care Organizations expanded face-to-face visits to all MLTSS Members and resumption of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. In addition, the NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting* was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2022 to June 30, 2023.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 135 cases for Aetna Better Health of New Jersey (ABHNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS 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 MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within 45 days of MLTSS enrollment).

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

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

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 135 cases selected for Aetna Better Health of New Jersey (ABHNJ), 127 Member files were reviewed and 122 were included in the results:

Description	Group C	Group D	Group E	Ancillary Group	Subtotal
Total Number of Files Reviewed	21	55	26	25	127
Exclusions	1	2	1	1	5
Number of Files included in Results	20	53	25	24	122

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits *or* Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's audit results for the combined MLTSS sample ranged from 74.3% to 98.6% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 1, 2022 – June 30, 2023			
Determination by Category	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	100.0%	96.0%	98.4%
Member Outreach	95.0%	100.0%	--	98.6%
Face-to-Face Visits *or* Telephonic Monitoring	72.3%	78.1%	66.7%	74.3%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	95.7%	97.1%	91.1%	95.3%
Ongoing Care Management	80.0%	90.0%	73.8%	84.9%
Gaps in Care/Critical Incidents	100.0%	100.0%	85.1%	96.2%

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

[2]Member outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 21 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). 1 file was excluded. All 20 files were further reviewed for compliance in 6 categories. There were 12 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJCA for the Member from OCCO.*	13	20	65.0%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	13	13	100.0%
OCCO response was received within 5 business days of the MCO request.*	7	13	53.8%
The MCO received a NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	13	0.0%
OCCO completed the NJ Choice Assessment which is valid during the review period.*	2	20	10.0%
The MCO completed the NJ Choice Assessment with the Member.	18	18	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	19	20	95.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	20	20	100.0%
Member is unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.[1]	7	18	38.9%
Member was offered the participant direction option.[2]	8	8	100.0%
Member chose to participate in participant direction. (excludes Members residing in CARS).*	1	8	12.5%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[2]	1	1	100.0%

Member had a completed and signed Interim Plan of Care (IPOC).[1]	16	18	88.9%
A cost effective analysis was completed during the review period.	15	20	75.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	15	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members where OCCO completed the New Jersey Choice Assessment
[2]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	17	20	85.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	20	20	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	0	8	0.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	8	8	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	5	8	62.5%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	3	8	37.5%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	20	20	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	19	20	95.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	20	20	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	19	20	95.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	8	8	100.0%

Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	8	8	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	8	8	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	8	8	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	8	8	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	8	8	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	19	20	95.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	19	20	95.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	8	8	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	8	8	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	8	8	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	6	8	75.0%
Member experienced issues that impeded access to care.*	5	20	25.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	5	5	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	16	20	80.0%
Member required a change in Plan of Care based on an increase or reduction of services. *	4	20	20.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	3	4	75.0%
Member file indicates disagreement with the Plan of Care.*	0	1	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	20	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	3	5	60.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	5	5	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	2	3	66.7%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a Community Alternative Residential Setting (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	8	8	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS)*	0	8	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	20	20	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 55 files were reviewed for Members currently enrolled in managed care and newly eligible for MLTSS (Group D). 2 files were excluded. All 53 files were further reviewed for compliance in all 6 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an SCS tool completed.*	52	53	98.1%
Member enrolled into MLTSS on an SCS Waiver.*	49	52	94.2%
NJCA completed within 30 days of a referral to MLTSS.	3	3	100.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	53	53	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	53	53	100.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	53	53	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	9	53	17.0%
Member had PPP services prior to MLTSS enrollment (excludes Members residing in CARS).*	0	52	0.0%
Member was offered the participant direction option.[1]	52	52	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	25	52	48.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	25	25	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	48	53	90.6%
A cost effective analysis was completed during the review period.	50	53	94.3%

The Member reached or exceeded 85% of the annual cost threshold (ACT).*	1	50	2.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	1	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	48	53	90.6%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	53	53	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	4	52	7.7%
Member was assessed for PCA services (excludes Members residing in CARS).*	47	48	97.9%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	44	47	93.6%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	1	47	2.1%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	53	53	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	52	53	98.1%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	53	53	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	52	53	98.1%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	51	52	98.1%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	51	51	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	51	51	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	51	51	100.0%

Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	40	51	78.4%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	51	52	98.1%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	53	94.3%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	53	53	100.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	52	52	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	51	52	98.1%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	51	51	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	49	52	94.2%
Member experienced issues that impeded access to care.*	13	53	24.5%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	13	13	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	42	53	79.2%
Member required a change in Plan of Care based on an increase or reduction of services.*	5	53	9.4%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	5	5	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A

The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	53	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	8	8	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	8	8	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	52	52	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	2	52	3.8%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	53	53	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 26 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). 1 file was excluded. The Member Outreach category is not assessed for Group E, as these Members are not new to MLTSS. All 25 files were reviewed for compliance in 5 categories. There were 4 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	24	25	96.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	24	25	96.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	4	24	16.7%
Member had PPP services prior to MLTSS enrollment (excludes Members residing in CARS).*	1	21	4.8%
Member was offered the participant direction option.[1]	19	20	95.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	6	19	31.6%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	6	6	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	18	24	75.0%
A cost effective analysis was completed during the review period.	19	25	76.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	19	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	23	24	95.8%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	25	25	100.0%
Member required another PCA assessment due to changes in condition. (excludes Members residing in CARS)*	1	21	4.8%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	24	24	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	20	25	80.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	20	25	80.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	18	21	85.7%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	18	18	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	18	18	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	18	18	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	13	18	72.2%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	17	21	81.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	20	25	80.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	20	25	80.0%

Care Manager completed an Annual Risk Assessment for the Member.[1]	21	21	100.0%
Members who were identified as having a positive risk.*	19	21	90.5%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	18	19	94.7%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.[2]	0	2	100.0%[2]

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases

Ongoing Care Management	**N**	**D**	**Rate**
Member experienced issues that impeded access to care.*	4	25	16.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	4	4	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	14	25	56.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	2	25	8.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	2	2	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	4	4	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	4	4	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and verbally acknowledged by the Member and/or authorized representative.	2	2	100.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	1	1	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	18	21	85.7%
Member reported a gap in service delivery (excludes Members in CARS)*	1	21	4.8%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	21	25	84.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment, #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change in Member condition), #10 (Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan, and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2022-2023 audit findings. Overall, ABHNJ's audit results ranged from 83.3% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	17	20	85.0%
	Group D	48	53	90.6%
	Group E[4]			
	Ancillary C	5	6	83.3%
	Ancillary D	17	18	94.4%
	Total	87	97	89.7%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	23	25	92.0%
	Total	23	25	92.0%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	Group C	2	3	66.7%
	Group D	1	1	100.0%
	Group E	2	2	100.0%
	Total	5	6	83.3%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	20	20	100.0%
	Group D	53	53	100.0%
	Group E	24	24	100.0%
	Total	97	97	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	19	20	95.0%
	Group D	52	53	98.1%
	Group E	20	25	80.0%
	Total	91	98	92.9%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	8	8	100.0%
	Group D	51	52	98.1%
	Group E	18	21	85.7%
	Total	77	81	95.1%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	20	20	100.0%
	Group D	53	53	100.0%
	Group E	21	25	84.0%
	Total	94	98	95.9%

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

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

[3]Members residing in a community alternative residential setting (CARS) are excluded from this measure

[4]Group E Members are excluded from this measure as they are not new to MLTSS
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure

Discussion

Limitations

COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. The MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5). Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could only be evaluated for those Members not enrolled through the SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below. Opportunities for Improvement for elements at the group level with a score below 86% are provided for the following categories: Face to Face/Telephonic Monitoring, Ongoing Care Management, and Gaps in Care.

Assessment

Across all three groups, the MCO had a combined score of 98.4% in the Assessment category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	100.0%
Group E	96.0%
Combined	98.4%

Member Outreach

Across groups, the MCO had a combined score of 98.6% in the Member Outreach category.

Group	7/1/22 to 6/30/23
Group C	95.0%
Group D	100.0%
Group E[1]	
Combined	98.6%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Face-to-Face Visits or Telephonic Monitoring

Across all three groups, the MCO had a combined score of 74.3% in the Face-to-Face Visits *or* Telephonic Monitoring category.

Group	7/1/22 to 6/30/23
Group C	72.3%
Group D	78.1%
Group E	66.7%
Combined	74.3%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Face-to-Face Visits or* Telephonic Monitoring category include the following:

- Group C: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling and that a cost effective analysis (CEA) is completed during the review period.
- Group D: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling.
- Group E: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling, the Interim Plan of Care (IPOC) is completed and signed, and that a cost effective analysis (CEA) is completed during the review period.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 95.3% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/22 to 6/30/23
Group C	95.7%
Group D	97.1%
Group E	91.1%
Combined	95.3%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 84.9% in the Ongoing Care Management category.

Group	7/1/22 to 6/30/23
Group C	80.0%
Group D	90.0%
Group E	73.8%
Combined	84.9%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Ongoing Care Management* category include the following:

- Group C: ABHNJ should ensure that the Member has MLTSS services in place timely, within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard). ABHNJ should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). ABHNJ should ensure that for Member files that indicate a change from the initial Plan of Care has documentation that the Member's Plan of Care was updated and/or reviewed, Member agrees with the Plan of Care, Member signed/verbally acknowledged, and is provided with a copy of the Plan of Care. ABHNJ should ensure that for Members who are discharged to an HCBS setting, the onsite review occurs timely, within 10 days of discharge. ABHNJ should ensure that for Plans of Care that have been reviewed and amended due to a significant change, the Care Manager obtains Member/authorized representative's signature and/or verbal acknowledgement.

- Group E: ABHNJ should ensure that the Member has a documented face-to-face/telephonic visit to review placement and services during the review period that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 96.2% in the Gaps in Care/Critical Incidents category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	100.0%
Group E	85.1%
Combined	96.2%

Opportunities for Improvement for elements at the group level *with a score less than 86%* in the *Gaps in Care/Critical Incidents* category include the following:

- Group E: For Members receiving MLTSS services (excludes Members residing in CARS), ABHNJ should ensure the Care Manager reviews the process for immediately reporting gaps in service delivery and the Member's rights and

responsibilities under the MLTSS program; including the procedures for filing a grievance and/or an appeal and how to report a critical incident.

Performance Measures

Overall, ABHNJ scored below 86% in one (1) of the seven (7) Performance Measures.

PM #9a. Plan of Care for MLTSS Members amended based on change in Member condition.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- Group C: ABHNJ should ensure that Plans of Care are signed/verbally acknowledged by the Member and/or authorized representative, and a copy is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment.

PM #9a: Plan of Care for MLTSS Members amended based on change in Member condition.

- Group C: ABHNJ should ensure that an amended Plan of Care is signed by the Member and/or authorized representative.

PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles."

- Group E: ABHNJ should ensure the Member's Plan of Care developed using "Person-Centered Principles" is signed/verbally acknowledged by the Member and/or authorized representative.

PM #12: MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.

- Group E: ABHNJ should ensure that MLTSS HCBS Plans of Care include a completed Back-up Plan signed by the Member and/or authorized representative.

PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

- Group E: ABHNJ should ensure that the Care Manager provides training to MLTSS Members on identifying/reporting Critical Incidents.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2023 Annual Assessment Review of Care Management
Aetna Better Health of New Jersey

Review Period - July 1, 2022 to June 30, 2023
December 2023

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standards under review; interviews with key ABHNJ staff (held via Teams meeting on November 29, 2023) and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on July 25, 2023, and received from the MCOs on August 7, 2023. The documentation review occurred offsite at IPRO beginning on August 8, 2023. The IPRO review team consisted of Carla Zuccarello, Cynthia Santangelo, Rachel Fahey, and Lois Heffernan. The Care Management assessment covered the period from July 1, 2022 to June 30, 2023. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2023 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be submitted once completed.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. ABHNJ received an overall compliance score of 100% in 2023. In 2022, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Aetna Better Health of New Jersey

November 2023

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Better healthcare,
realized.

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1st through June 30th. Due to COVID-19 pandemic, the prior review period was from January 1, 2021 through August 14, 2021, during which time face to face visits were suspended and access to Nursing facilities was restricted. The review period for this audit was August 15, 2021 through August 31, 2022, during which time DMAHS issued the MCO Care Management Visit Guidance. Effective November 16, 2021, MCO Care Managers were to expand face to face visits to all MLTSS Members and resume completion of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities, allowing telephonic visits for Members who refused an in person visit, and for Nursing Facilities with visitation protocols restricting Care Manager access. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the *MCO Contracts* in *Article 9* from the *State of New Jersey DHS, DMAHS MCO Contract* to provide services dated July 2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022, to coincide with the State's *extension deadline for return to field activities,* disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to a NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

Capitation Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Aetna Better Health of New Jersey (ABHNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on August 31, 2022.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on August 31, 2022.
- The Member cannot have been enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (August 31, 2022).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from August 15, 2021 to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from August 15, 2021 to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files, and uploading the files to IPRO's File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a 4-week period. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for ABHNJ, 101 Member files were reviewed and included in the results pertaining to the Plan of Care for institutional settings. One (1) file was excluded for not meeting eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" were not included in scoring. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Tables 4–7**). A total of 100 files were reviewed for requirements regarding the Facility and MCO Plan of Care (**Table 4**), MLTSS Initial Plan of Care and Ongoing Plans of Care (**Table 5**), Transition Planning (**Table 6**), and Reassessment of the Plan of Care and Critical Incident Reporting (**Table 7**). Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–7**).

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	79	100	79.0%
Documented review of the Facility Plan of Care by the Care Manager.	73	79	92.4%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	73	79	92.4%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	0	4	0.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	76	100	76.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	76	100	76.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	76	100	76.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1-Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	76	100	76.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	76	100	76.0%
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	1	100.0%

Table 6: Transition Planning

Transition Planning	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	6	100	6.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	45	100	45.0%

Transition Planning	N	D	Rate
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	81	100	81.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	23	100	23.0%
Members requiring coordination of care had coordination of care by the Care Manager.	99	100	99.0%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission.	72	100	72.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	62	100	62.0%
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.	75	100	75.0%
Care Manager reviewed the Member's rights and responsibilities.	76	100	76.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	76	100	76.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	75	100	75.0%

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for ABHNJ, 100 Member files were reviewed and included in the results. Rates were calculated for state-requirement–specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 8**).

Table 8: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Table 9** and **Table 10**). Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4; **Table 9**). Rates were calculated to profile NF/SCNF Members that transitioned to HCBS.

Table 9: NF/SCNF Members Transitioned to HCBS

Transition to HCBS	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
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting 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
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: not applicable.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for Members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4; **Table 10**). Rates were calculated to profile HCBS Members that transitioned to a NF/SCNF.

Table 10: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member had a person-centered transition plan on file.	0	0	N/A
Member participated in a therapeutic leave.	0	0	N/A
Care Manager completed a risk management agreement for the Member when indicated.	0	0	N/A
Member was admitted to NF/SCNF directly from an acute facility.	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: not applicable.

The expansion of the NF audit components included evaluating the NF/SCNF population on the MLTSS PMs. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings are presented in **Table 11**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #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), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents).

Population results are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations (**Table 11)**.

Table 11: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	0	4	0.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[2]	76	100	76.0%
#9a. Member's Plan of Care is amended based on change of Member condition[3]	1	1	100.0%
#11. Plans of Care developed using "person-centered principles"[4]	76	100	76.0%
#16. Member training on identifying/reporting critical incidents	75	100	75.0%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an Initial Plan of Care.
[2] 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 and the end of the study period.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] 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 Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–7**):

- Documented Review of the Facility Plan of Care (92.4%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (92.4%)
- 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 (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (99.0%)

Opportunities for Improvement for Audit Elements

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an Institutional Setting (**Tables 4–7**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (79.0%)
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS) (0.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (76.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (76.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (76.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (76.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (76.0%)

- Member was identified for transfer to HCBS and was offered options, including transfer to the community (6.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (Participation in an IDT meeting may be substituted for one Member visit) (45.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (81.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Telephonic or 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) (23.0%)
- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (72.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (62.0%)
- 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 (75.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (76.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (76.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (75.0%)

Recommendations for Audit Elements

Aetna's MLTSS Care Managers should ensure that the Member's care management record contains a copy of the Facility Plan of Care during the review period, ensure the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within forty five (45) calendar days of MLTSS enrollment. Care Managers should utilize a person-centered approach when assessing the Member's needs and in the development of the care plan, addressing both formal and informal supports and services. Care Managers should ensure Member goals, developed during the Plan of Care process, are built on Member's identified needs, strengths, support systems, and include measures to achieve their goals, and ensure the Member's agreement/disagreement with Plan of Care statements are documented in the file. Care Managers should identify Members for transfer to HCBS and offer options including transfer to the community. Care Managers should participate in at least one Interdisciplinary Team meeting during the review period, ensure the Member is present at each onsite/telephonic visit or have involvement from the Member's authorized representative regarding the Plan of Care, ensure onsite/telephonic visits are timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members, explain and discuss any payment liability relating to the Member's NF/SCNF admission (if applicable), ensure NJCA is completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment, ensure that the Plan of Care is updated, reviewed, and signed by the Member and/or representative and a copy is provided to the Member and/or representative, review the Member's Rights and Responsibilities under the MLTSS program, educate the Member on how to file a grievance and/or an appeal, and provide Member training on how to identify/report a critical incident, and how to identify abuse, neglect and exploitation.

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (**Table 11**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (0.0%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the Member's Anniversary and as necessary (76.0%)
- #11. Plans of Care developed using "person-centered principles" (76.0%)
- #16. Member training on identifying/reporting critical incidents (75.0%)

Recommendations for MLTSS Performance Measures

ABHNJ's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS, review Member's Plan of Care annually within 30 days of the Member's anniversary and as necessary, and develop Member's Plan of Care using "person-centered principles". MLTSS Care Managers should provide Member training on identifying/reporting critical incidents.

As presented in **Table 9**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to HCBS. Since no files were reviewed in this category, specific conclusions and recommendations could not be determined. As presented in **Table 10**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix C: AGNJ 2023 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Amerigroup New Jersey

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

November 2023

Corporate Headquarters
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MCO Care Management Chart Audit

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, NJ Care Management Workbook, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology, as shown in Table 1, resulted in the selection of 194 cases for Amerigroup New Jersey (AGNJ), including a 10% oversample for the General Population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range

within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) was selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (15). All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (69).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. AND (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499). Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2022	>= 3 months as of 12/31/2022	>= 3 months and < 18 years as of 12/31/2022
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2022 and 7/1/2022	Initial enrollment between 1/1/2022 and 12/31/2022	Initial enrollment between 1/1/2022 and 12/31/2022
• Existing Enrollees	Enrolled prior to 1/1/2022		
Current Enrollment	Enrolled as of 12/31/2022	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2022 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

AGNJ 2023 CM Audit results for the review period 1/1/2022 to 12/31/2022 ranged from 46% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=15)	DCP&P (n=26)
Identification[1]	72%		
Outreach	81%	100%	97%
Preventive Services	46%	62%	81%
Continuity of Care	59%	95%	95%
Coordination of Services	83%	100%	100%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 26 Enrollees were New Enrollees, and 74 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	GP Population		
	Numerator	Denominator	Rate
Enrollee has an IHS on file completed during the audit period (1/1/22 to 12/31/22) (applies to New Enrollees only)*	0	26	0.0%
IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only)	0	0	NA[1]
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS)*	1	26	3.8%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only)	24	25	96.0%
Enrollees identified by the Plan as having potential Care Management needs (applies to New Enrollees only where IHS score is less than 5 or no IHS on file)*	15	26[2]	57.7%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to New Enrollees only)	8	11	27.3%[3]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2021 or existing Enrollees newly enrolled in CM during the review period)*	11	74	14.9%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to Existing Enrollees enrolled prior to 11/16/2021)	19	63	69.8%[3]
Enrollees identified by the Plan as having potential Care Management needs (applies to Existing Enrollees not enrolled in Care Management prior to 11/16/2021 or during the review period).*	41	44	93.2%

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

[2]Denominator includes 26 cases with no IHS on file.

[3]Percentage rate is indicative of an inverse percentage – higher score is indicative of positive performance

Outreach

This section applies only to Existing Enrollees not in Care Management prior to 11/16/21 where the MCO identified need, and to New Enrollees where the MCO identified need based on an IHS score greater than or equal to 5, or through other means where no IHS was on file or the IHS score was less than 5.

Table 4: Outreach – GP Population

Outreach	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	61	100	61.0%
The MCO completed a CNA during the audit period*	9	61	14.8%
For Enrollees with no CNA on file, initial outreach to complete a CNA was done	36	52	69.2%
For Enrollees with no CNA on file, the outreach for CNA was timely within 30 days of the identification of CM needs	35	36	97.2%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	7	36	19.4%
Aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	25	36	69.4%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	25	25	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	6	7	85.7%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	6	7	85.7%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees in Care Management during the review period. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. AGNJ had a total of 15 cases in the General Population who were in Care Management during the review period.

Table 5: Preventive Services – GP Population

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	4	6	66.7%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	2	2	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	2	2	100.0%

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	1	6	16.7%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	1	5	20.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	2	9	22.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	1	7	14.3%
Dental needs are addressed for Enrollees (aged 21 and above)	3	9	33.3%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	2	3	66.7%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	1	1	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	1	1	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	3	0.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	3	3	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	3	3	100.0%

**Not Included in aggregate score calculation*

Continuity of Care

This section includes Enrollees in Care Management during the review period (15). Four (4) cases were in Care Management prior to 11/16/21. Eleven (11) cases (5 New Enrollees and 6 Existing Enrollees) were new to Care Management during the review period. Community Based Care Management is reported based on files received from the MCO.

Table 6: Continuity of Care – GP Population

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	61	100	61.0%
The MCO completed a CNA during the audit period*	9	61	14.8%
For the Enrollees that completed a CNA during the audit period, the completed CNA contained all elements of the State approved CNA tool	9	9	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file	0	0	NA[1]
A level of Care Management was determined for the Enrollee	8	9	88.9%
The Enrollee is in Community Based Care Management (CBCM). Does not include Enrollees who declined Care Management*	5	15	33.3%

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
A Care Plan was completed for the Enrollee that included all required components	8	15	53.3%
The Care Plan was developed within 30 days of CNA completion	5	9	55.6%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances or, for Existing Enrollees with no identified change in needs, Care Plan was monitored.	8	8	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	8	28	28.6%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Coordination of Services

This section includes Enrollees in Care Management during the review period (15). Four (4) cases were in Care Management prior to 11/16/21. Eleven (11) cases (5 New Enrollees and 6 Existing Enrollees) were new to Care Management during the review period.

Table 7: Coordination of Services – GP Population

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	14	15	93.3%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	12	14	85.7%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	11	14	78.6%
For Enrollees who were hospitalized, adequate discharge planning was performed	8	11	72.7%

DDD Population Findings

A total of 15 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	15	15	100.0%
Initial outreach to complete a CNA was done	15	15	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	0	0	NA[1]
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	0	0	NA[1]
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	0	0	NA[1]
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	0	0	NA[1]

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DDD Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. AGNJ had a total of 15 cases in the DDD Population.

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	3	4	75.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	1	2	50.0%

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	0	1	0.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	7	13	53.8%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	6	6	100.0%
Dental needs are addressed for Enrollees (aged 21 and above)	5	11	45.5%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	3	4	75.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	1	1	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	0	1	0.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	0	NA[1]
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	0	0	NA[1]

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DDD Members (15).

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	15	15	100.0%
The completed CNA contained all elements of the State approved CNA tool	15	15	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	13	15	86.7%
A level of Care Management was determined for the Enrollee	15	15	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	0	15	0.0%
A Care Plan was completed for the Enrollee that included all required components	15	15	100.0%
The Care Plan was developed within 30 days of CNA Completion	15	15	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	5	6	83.3%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan	0	1	0.0%

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

Coordination of Services

This section applies to all DDD Members (15).

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	15	15	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	13	13	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	15	15	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2022 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	NA[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	NA[1]

[1]NA: Not Applicable

DCP&P Population Findings

A total of 69 files were reviewed for the DCP&P Population. (43) files were excluded from the DCP&P Population and were not subject to further review in the following categories. AGNJ had a total of 26 cases in the DCP&P Population.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	23	26	88.5%
Initial outreach to complete a CNA was done	26	26	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	2	3	66.7%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	0	3	0.0%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	3	3	100.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	3	3	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	0	0	NA[1]

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DCP&P Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. AGNJ had a total of 26 cases in the DCP&P Population.

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	23	26	88.5%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	3	3	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	3	3	100.0%

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	18	26	69.2%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	7	8	87.5%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	0	0	NA[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	0	0	NA[1]
Dental needs are addressed for Enrollees (aged 21 and above)			
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	11	22	50.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	11	11	100.0%
Dental reminders were sent to Enrollees(aged 1 through 20)	11	11	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	4	6	66.7%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	2	2	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	6	6	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DCP&P Members (26).

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	23	26	88.5%
The completed CNA contained all elements of the State approved CNA tool	23	23	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	22	23	95.7%
A level of Care Management was determined for the Enrollee	23	23	100.0%
A Care Plan was completed for the Enrollee that included all required components	25	26	96.2%
The Care Plan was developed within 30 days of CNA Completion	22	23	95.7%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	9	13	69.2%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan	2	2	100.0%

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

Coordination of Services

This section applies to all DCP&P Members (26).

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	26	26	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	20	20	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	25	25	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	6	6	100.0%

Limitations

Audit results for the DDD and DCP&P Populations should be considered cautiously due to the low sample size of 15 and 26 respectively.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (DDD Population) (100%)
- Continuity of Care (DDD Population) (95%)
- Coordination of Services (DDD Population) (100%)

- Outreach (DCP&P Population) (97%)
- Continuity of Care (DCP&P Population) (95%)
- Coordination of Services (DCP&P Population) (100%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (72%)
- Outreach (General Population) (81%)
- Preventive Services (General Population) (46%)
- Continuity of Care (General Population) (59%)
- Coordination of Services (General Population) (83%)

- Preventive Services (DDD Population) (62%)

- Preventive Services (DCP&P Population) (81%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Amerigroup New Jersey (AGNJ), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key AGNJ staff via WebEx held on May 9, 2023; and post audit evaluation of documentation and audit activities.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the audit review was requested by IPRO on February 10, 2023, and documentation was received from the MCOs on February 27, 2023. The documentation review occurred offsite at IPRO beginning on February 28, 2023. The audit review team was made up of Carla Zuccarello, Donna Reinholdt, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2022 to December 31, 2022.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. AGNJ received an overall compliance score of 73% in 2023. In 2022, the MCO received a score of 77%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2023. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	-	-	X	-	X	-	-
CM4	X	X	-	-	-	-	-
CM5	X	-	X	-	-	-	X
CM6	-	X	-	-	-	X	-
CM7	-	-	X	-	X	-	-
CM8	-	-	X	-	X	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	-	X	-	-	-	X
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	-	X	-	-	-	X
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	-	X	-	-	-	X	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**23**	**22**	**8**	**0**	**5**	**2**	**3**
Compliance Percentage		**73%**					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 72.7% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 27.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees enrolled prior to 11/16/2021). 69.8% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021).
CM5	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:**

Element	Contract Language	Reviewer Comments
	Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic, and hospital.	78.6% - For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO's assessment tool.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 69.2% - For Enrollees with no CNA on file, initial outreach to complete a CNA was done. **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 66.7% - The outreach for CNA was timely within 45 days of enrollment.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan, and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 53.3% - A Care Plan was completed for the Enrollee that included all the required components. 55.6% **-** The Care Plan was developed within 30 days of CNA completion.

Element	Contract Language	Reviewer Comments
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires, and level of self-direction of the Enrollee and/or caregiver.	**In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 83.3% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances. **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 69.2% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 66.7% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 16.7% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 20.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 22.2% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 14.3% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 33.3% - Dental needs are addressed for Enrollees (aged 21 and above). 66.7% - A dental visit occurred during the review period for Enrollees (aged 1 through 20).

Element	Contract Language	Reviewer Comments
		In the 2023 CM file audit the MCO scored for the DDD Enrollees: 75.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (0 through 20). 50.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 0.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 53.8% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 45.5% - Dental needs are addressed for Enrollees (aged 21 and above). 75.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). 0.0% - Dental reminders were sent to Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 69.2% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 50.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20).
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without reasonable interruption.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 28.6% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was

Element	Contract Language	Reviewer Comments
		given a comprehensive treatment plan to address the Enrollee's specific needs. **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 0.0% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.

Recommendations

For the General Population:

1. **CM2:** AGNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed.
2. **CM3:** For New and Existing Enrollees, AGNJ should ensure that they appropriately identify Enrollees with potential CM needs.
3. **CM5:** AGNJ should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.
4. **CM7:** AGNJ should ensure that Initial outreach to complete a CNA is done.
5. **CM8:** AGNJ should ensure that the Care Plan is developed within 30 days of CNA completion, and the Care Plan includes all the required components.
6. **CM14:** AGNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
7. **CM14:** AGNJ should ensure the Enrollee's (aged 0 through 18) immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status.
8. **CM14:** AGNJ should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above) and aggressive outreach attempts are documented to confirm immunization status.
9. **CM14:** AGNJ should ensure that dental needs are addressed for Enrollees (aged 21 and above).
10. **CM14:** For Enrollees (aged 1 through 20), AGNJ should ensure that a dental visit occurs during the review period.
11. **CM15:** For Enrollees demonstrating needs requiring a treatment plan, AGNJ should ensure the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.

For the DDD Population:

1. **CM11:** AGNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.
2. **CM14:** AGNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source.
3. **CM14:** AGNJ should ensure the Enrollee's (aged 0 through 18), immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status.
4. **CM14:** AGNJ should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above).
5. **CM14:** AGNJ should ensure that dental needs are addressed for Enrollees (aged 21 and above).
6. **CM14:** For Enrollees (aged 1 through 20), AGNJ should ensure that a dental visit occurs during the review period and dental reminders are sent.
7. **CM15:** For Enrollees demonstrating needs requiring a treatment plan, AGNJ should ensure the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.

For the DCP&P Population:

1. **CM7:** AGNJ should ensure that outreach for CNA is done timely within 45 days of enrollment.
2. **CM11:** AGNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.
3. **CM14:** AGNJ should ensure the Enrollee's (aged 0 through 18) immunizations are up to date and immunization status is confirmed by a reliable source.
4. **CM14:** For Enrollees (aged 1 through 20), AGNJ should ensure that a dental visit occurs during the review period.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Amerigroup New Jersey, Inc.

Review Period July 1, 2022 – June 30, 2023

February 2024

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following State guidance, Managed Care Organizations expanded face-to-face visits to all MLTSS Members and resumption of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. In addition, the NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting* was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2022 to June 30, 2023.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 135 cases for Amerigroup New Jersey, Inc. (AGNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS 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 MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within 45 days of MLTSS enrollment).

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

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

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 135 cases selected for the Amerigroup New Jersey, Inc. (AGNJ), 127 Member files were reviewed and 123 were included in the results:

Description	Group C	Group D	Group E	Ancillary Group	Subtotal
Total Number of Files Reviewed	6	69	27	25	127
Exclusions	0	0	2	2	4
Number of Files included in Results	6	69	25	23	123

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits *or* Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

AGNJ's audit results for the combined MLTSS sample ranged from 70.3% to 99.2% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 1, 2022 to June 30, 2023			
Determination by Category	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	98.6%	100.0%	99.2%
Member Outreach	83.3%	73.9%	--	74.7%
Face-to-Face Visits *or* Telephonic Monitoring	100.0%	98.6%	98.9%	98.7%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	98.9%	96.8%	98.5%	97.3%
Ongoing Care Management	85.7%	76.2%	41.9%	70.3%
Gaps in Care/Critical Incidents	100.0%	98.6%	100.0%	99.0%

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

[2]Member outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 6 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). No files were excluded. All 6 files were further reviewed for compliance in 6 categories. There was 1 Member residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJCA for the Member from OCCO.*	2	6	33.3%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	2	2	100.0%
OCCO response was received within 5 business days of the MCO request.*	1	2	50.0%
The MCO received a NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	1	2	50.0%
OCCO completed the NJ Choice Assessment which is valid during the review period.*	2	6	33.3%
The MCO completed the NJ Choice Assessment with the Member.	4	4	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	5	6	83.3%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	6	6	100.0%
Member is unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.[1]	4	4	100.0%
Member was offered the participant direction option.[2]	5	5	100.0%
Member chose to participate in participant direction. (excludes Members residing in CARS).*	4	5	80.0%

Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[2]	4	4	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).[1]	4	4	100.0%
A cost effective analysis was completed during the review period.	6	6	100.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	6	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2] Denominator excludes Members residing in CARS

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	6	6	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	6	6	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	0	5	0.0%
Member was assessed for PCA services (excludes Members residing in CARS)*	5	5	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	4	5	80.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS)*	1	5	20.0%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	6	6	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	6	6	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	6	6	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express	6	6	100.0%

his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.			
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	5	5	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	5	5	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	5	5	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	5	5	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	5	5	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	5	5	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	6	6	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	6	6	100.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	5	5	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	5	5	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	5	5	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	5	5	100.0%
Member experienced issues that impeded access to care.*	0	6	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	4	6	66.7%
Member required a change in Plan of Care based on an increase or reduction of services. *	2	6	33.3%

Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	2	2	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	6	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	0	0	N/A
Member was discharged to his/her own home and in home services were in place in a timely manner.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	1	1	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.[1]	5	5	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS)*	0	5	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	6	6	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 69 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). No files were excluded. All 69 files were further reviewed for compliance in all 6 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an SCS tool completed.*	66	69	95.7%
Member enrolled into MLTSS on an SCS Waiver.*	65	66	98.5%
NJCA completed within 30 days of a referral to MLTSS.	0	1	0.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	68	68	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	51	69	73.9%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	68	69	98.6%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite/telephonic meeting with the Care Manager.*	1	1	100.0%
Member or authorized representative refused to participate in any face-to-face visits.*	1	1	100.0%
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	1	1	100.0%
Options Counseling was provided to the Member.	68	68	100.0%
Member had PPP services prior to MLTSS enrollment (excludes Members in CARS).*	4	67	6.0%
Member was offered the participant direction option.[1]	63	63	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	20	63	31.7%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	20	20	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	68	68	100.0%

A cost effective analysis was completed during the review period.	65	69	94.2%
The Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	65	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	56	69	81.2%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	68	69	98.6%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	7	67	10.4%
Member was assessed for PCA services (excludes Members residing in CARS).*	37	60	61.7%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	26	37	70.3%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	5	37	13.5%
Member was re-assessed for PCA due to changes in condition.[1]	4	5	80.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	68	68	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	68	69	98.6%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	68	68	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	68	68	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	66	67	98.5%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	66	66	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	66	66	100.0%

Member service preference levels were documented in the Back-up Plan.[1]	66	66	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	63	66	95.5%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	66	67	98.5%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	67	69	97.1%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	68	69	98.6%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	66	67	98.5%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	66	66	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	66	66	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	60	67	89.6%
Member experienced issues that impeded access to care.*	4	69	5.8%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	4	4	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	42	69	60.9%
Member required a change in Plan of Care based on an increase or reduction of services.*	7	69	10.1%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	7	7	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	69	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	4	9	44.4%
Member was discharged to his/her own home and in home services were in place in a timely manner.	7	9	77.8%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	7	7	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	66	67	98.5%
Member reported a gap in service delivery (excludes Members residing in CARS).*	2	67	3.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	68	69	98.6%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 27 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). 2 files were excluded. The Member Outreach category is not assessed for Group E, as these Members are not new to MLTSS. All 25 files were reviewed for compliance in 5 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	25	25	100.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	25	25	100.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	25	25	100.0%
Member had PPP prior to MLTSS enrollment (excludes Members in CARS).*	11	24	45.8%
Member was offered the participant direction option.[1]	13	13	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	0	13	0.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	0	0	N/A
Member had a completed and signed Interim Plan of Care (IPOC).	25	25	100.0%
A cost effective analysis was completed during the review period.	24	25	96.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	24	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	25	25	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	25	25	100.0%
Member required another PCA assessment due to changes in condition. (excludes Members residing in CARS)*	1	24	4.2%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	25	25	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	21	24	87.5%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	21	21	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	21	21	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	21	21	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	19	21	90.5%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	24	24	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	25	25	100.0%

The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	23	24	95.8%
Members who were identified as having a positive risk.*	23	23	100.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	23	23	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.[1]	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	4	25	16.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	4	25	16.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	4	4	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	2	6	33.3%
Member was discharged to his/her own home and in home services were in place in a timely manner.	6	6	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	2	2	100.0%

Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	24	24	100.0%
Member reported a gap in service delivery (excludes Members in CARS)*	1	24	4.2%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment, #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change in Member condition), #10 (Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan, and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2022-2023 audit findings. Overall, AGNJ's audit results ranged from 81.6% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	6	6	100.0%
	Group D	56	69	81.2%
	Group E			
	Ancillary C	3	3	100.0%
	Ancillary D	15	20	75.0%
	Total	80	98	81.6%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C			
	Group D			
	Group E	25	25	100.0%
	Total	25	25	100.0%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	Group C	1	1	100.0%
	Group D	7	7	100.0%
	Group E	2	2	100.0%
	Total	10	10	100.0%
#10. Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment.	Group C	6	6	100.0%
	Group D	68	68	100.0%
	Group E	25	25	100.0%
	Total	99	99	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	6	6	100.0%
	Group D	68	68	100.0%
	Group E	25	25	100.0%
	Total	99	99	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan.[3]	Group C	5	5	100.0%
	Group D	66	67	98.5%
	Group E	21	24	87.5%
	Total	92	96	95.8%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	6	6	100.0%
	Group D	68	69	98.6%
	Group E	25	25	100.0%
	Total	99	100	99.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Members who did not have a documented change in condition during the study period are excluded from this measure
[3]Members residing in a community alternative residential setting (CARS) are excluded from this measure

Discussion

Limitations

COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. The MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5). Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could only be evaluated for those Members not enrolled through the SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below. Opportunities for Improvement for elements at the group level with a score below 86% are provided for the following categories: Member Outreach and Ongoing Care Management.

Assessment

Across all three groups, the MCO had a combined score of 99.2% in the Assessment category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	98.6%
Group E	100.0%
Combined	99.2%

Member Outreach

Across groups, the MCO had a combined score of 74.7% in the Member Outreach category.

Group	7/1/22 to 6/30/23
Group C	83.3%
Group D	73.9%
Group E[1]	
Combined	74.7%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Member Outreach* category include the following:

- Group C: AGNJ should ensure that initial outreach to schedule a face-to-face visit, for the purpose of creating an individualized and comprehensive Plan of Care occurs timely, within five (5) business days from the effective date of MLTSS enrollment.

- Group D: AGNJ should ensure that initial outreach to schedule a face-to-face visit, for the purpose of creating an individualized and comprehensive Plan of Care occurs timely, within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits or Telephonic Monitoring

Across all three groups, the MCO had a combined score of 98.7% in the Face-to-Face Visits *or* Telephonic Monitoring category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	98.6%
Group E	98.9%
Combined	98.7%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 97.3% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/22 to 6/30/23
Group C	98.9%
Group D	96.8%
Group E	98.5%
Combined	97.3%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 70.3% in the Ongoing Care Management category.

Group	7/1/22 to 6/30/23
Group C	85.7%
Group D	76.2%
Group E	41.9%
Combined	70.3%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Ongoing Care Management* category include the following:

- Group C: AGNJ should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- Group D: AGNJ should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). AGNJ should ensure that for Members who are discharged to a HCBS setting, the onsite review occurs within 10 days of discharge, and, the Member file contains documentation that in home services were in place in a timely manner.

- Group E: AGNJ should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). AGNJ should ensure for Members who are discharged to a HCBS setting, that the onsite review occurs within 10 days of discharge.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 99.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	98.6%
Group E	100.0%
Combined	99.0%

Performance Measures

Overall, AGNJ scored below 86% in one (1) of the seven (7) Performance Measures.

- **PM #8**. Plans of Care established within 45 days of MLTSS enrollment.

Opportunities for Improvement at the group level in MLTSS Performance Measures *with a score of less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- Group D: AGNJ should ensure that a copy of the initial Plan of Care is provided to the Member and/or authorized representative within 45 days of enrollment into MLTSS.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2023 Annual Assessment Review of Care Management
Amerigroup New Jersey, Inc.

Review Period - July 1, 2022 to June 30, 2023
December 2023

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by AGNJ as evidence of compliance of the standards under review; interviews with key AGNJ staff (held via Team meeting on November 28, 2023); and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on July 25, 2023, and received from the MCOs on August 7, 2023. The documentation review occurred offsite at IPRO beginning on August 8, 2023. The IPRO review team consisted of Carla Zuccarello, Cynthia Santangelo, Rachel Fahey, and Lois Heffernan. The Care Management assessment covered the period from July 1, 2022 to June 30, 2023. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met and therefore be considered full reviews every year.

Table 1: Rating scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2023 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be submitted once completed.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. AGNJ received an overall compliance score of 100% in 2023. In 2022, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Amerigroup New Jersey, Inc

November 2023

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1st through June 30th. Due to COVID-19 pandemic, the prior review period was from January 1, 2021 through August 14, 2021, during which time face to face visits were suspended and access to Nursing facilities was restricted. The review period for this audit was August 15, 2021 through August 31, 2022, during which time DMAHS issued the MCO Care Management Visit Guidance. Effective November 16, 2021, MCO Care Managers were to expand face to face visits to all MLTSS Members and resume completion of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities, allowing telephonic visits for Members who refused an in person visit, and for Nursing Facilities with visitation protocols restricting Care Manager access. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the *MCO Contracts* in *Article 9* from the *State of New Jersey DHS, DMAHS MCO Contract* to provide services dated July 2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022 to coincide with the State's *extension deadline for return to field activities*, disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to a NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

Capitation Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Amerigroup New Jersey, Inc. (AGNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on August 31, 2022.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on August 31, 2022.
- The Member cannot have been enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (August 31, 2022).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from August 15, 2021 to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from August 15, 2021 to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files, and uploading the files to IPRO's File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a 4-week period. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for AGNJ, 100 Member files were reviewed and included in the results pertaining to the Plan of Care for institutional settings. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" were not included in scoring. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Tables 4–7**). A total of 100 files were reviewed for requirements regarding the Facility and MCO Plan of Care (**Table 4**), MLTSS Initial Plan of Care and Ongoing Plans of Care (**Table 5**), Transition Planning (**Table 6**), and Reassessment of the Plan of Care and Critical Incident Reporting (**Table 7**). Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–7**).

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	97	100	97.0%
Documented review of the Facility Plan of Care by the Care Manager.	97	97	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	97	97	100.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	2	5	40.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	100	100	100.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	100	100	100.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	100	100	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	100	100	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	97	100	97.0%

MLTSS Initial Plan of Care and Ongoing Plans of Care	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	4	75.0%

Table 6: Transition Planning

Transition Planning	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	21	100	21.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	7	100	7.0%
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	100	100	100.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	66	100	66.0%
Members requiring coordination of care had coordination of care by the Care Manager.	100	100	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.	99	100	99.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	100	100	100.0%
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.	89	100	89.0%
Care Manager reviewed the Member's rights and responsibilities.	100	100	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	100	100	100.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	100	100	100.0%

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for AGNJ, 100 Member files were reviewed and included in the results. Rates were calculated for state-requirement–specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 8**).

Table 8: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Table 9** and **Table 10**). Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4; **Table 9**). Rates were calculated to profile NF/SCNF Members that transitioned to HCBS.

Table 9: NF/SCNF Members Transitioned to HCBS

Transition to HCBS	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
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting 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
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: not applicable.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for Members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4; **Table 10**). Rates were calculated to profile HCBS Members that transitioned to a NF/SCNF.

Table 10: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member had a person-centered transition plan on file.	0	0	N/A
Member participated in a therapeutic leave.	0	0	N/A
Care Manager completed a risk management agreement for the Member when indicated.	0	0	N/A
Member was admitted to NF/SCNF directly from an acute facility.	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: not applicable.

The expansion of the NF audit components included evaluating the NF/SCNF population on the MLTSS PMs. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings are presented in **Table 11**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #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), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations (**Table 11**).

Table 11: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	2	5	40.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[2]	100	100	100.0%
#9a. Member's Plan of Care is amended based on change of Member condition[3]	3	4	75.0%
#11. Plans of Care developed using "person-centered principles"[4]	100	100	100.0%
#16. Member training on identifying/reporting critical incidents	100	100	100.0%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an Initial Plan of Care.
[2] 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 and the end of the study period.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] 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 Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–7**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (97.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (100.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (100.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (97.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (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 (99.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (100.0%)
- 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 (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (100.0%)

Opportunities for Improvement for Audit Elements

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an institutional setting (**Tables 4–7**):

- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (40.0%)
- 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 (75.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (21.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (7.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (66.0%)

Recommendations for Audit Elements

AGNJ's MLTSS Care Managers should ensure the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within 45 calendar days of enrollment notification into the MLTSS program, ensure that the Plan of Care is updated for a significant change, identify Members for transfer to HCBS and offer Members options including transfer to the community, participate in at least one IDT meeting during the review period, and ensure telephonic or onsite visits are timely and occur within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members.

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (**Table 11**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (40.0%)
- #9a. Member's Plan of Care is amended based on change of Member condition (75.0%)

Recommendations for MLTSS Performance Measures

AGNJ's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS program and amend the Member's Plan of Care based on change of the Member's condition.

As presented in **Table 9**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to HCBS. Since no files were reviewed in this category, specific conclusions and recommendations could not be determined. As presented in **Table 10**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix D: HNJH 2023 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Horizon NJ Health

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

November 2023

IPRO
Better healthcare, realized.

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Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, NJ Care Management Workbook, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology, as shown in Table 1, resulted in the selection of 334 cases for Horizon NJ Health (HNJH), including a 10% oversample for the General Population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) was selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (84). All Enrollees were selected for the DCP&P Population as the total eligible population was (140) Enrollees.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. AND (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499). Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2022	>= 3 months as of 12/31/2022	>= 3 months and < 18 years as of 12/31/2022
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2022 and 7/1/2022	Initial enrollment between 1/1/2022 and 12/31/2022	Initial enrollment between 1/1/2022 and 12/31/2022
• Existing Enrollees	Enrolled prior to 1/1/2022		
Current Enrollment	Enrolled as of 12/31/2022	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2022 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH 2023 CM Audit results for the review period 1/1/2022 to 12/31/2022 ranged from 61% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=84)	DCP&P (n=97)
Identification[1]	75%		
Outreach	82%	96%	100%
Preventive Services	61%	81%	84%
Continuity of Care	86%	92%	95%
Coordination of Services	98%	100%	100%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 26 Enrollees were New Enrollees, and 74 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	GP Population		
	Numerator	Denominator	Rate
Enrollee has an IHS on file completed during the audit period (1/1/22 to 12/31/22) (applies to New Enrollees only)*	13	26	50.0%
IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only)	9	13	69.2%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS)*	0	13	0.0%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only)	7	13	53.8%
Enrollees identified by the Plan as having potential Care Management needs (applies to New Enrollees only where IHS score is less than 5 or no IHS on file)*	17	20[1]	85.0%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to New Enrollees only)	2	3	33.3%[2]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2021 or existing Enrollees newly enrolled in CM during the review period)*	8	74	10.8%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to existing Enrollees enrolled prior to 11/16/2021)	12	66	81.8%[2]
Enrollees identified by the Plan as having potential Care Management needs (applies to Existing Enrollees not enrolled in Care Management prior to 11/16/2021 or during the review period).*	28	54	51.9%

**Not Included in aggregate score calculation*

[1]Denominator includes 13 (thirteen) cases with no IHS on file and 7 (seven) cases with an IHS score less than 5

[2] Percentage rate is indicative of an inverse percentage – higher score is indicative of positive performance

Outreach

This section applies only to Existing Enrollees not in Care Management prior to 11/16/21 where the MCO identified need, and to New Enrollees where the MCO identified need based on an IHS score greater than or equal to 5, or through other means where no IHS was on file or the IHS score was less than 5.

Table 4: Outreach – GP Population

Outreach	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	53	100	53.0%
The MCO completed a CNA during the audit period*	5	53	9.4%
For Enrollees with no CNA on file, initial outreach to complete a CNA was done	37	48	77.1%
For Enrollees with no CNA on file, the outreach for CNA was timely within 30 days of the identification of CM needs	33	37	89.2%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	23	37	62.2%
Aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	20	37	54.1%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	16	20	80.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	22	23	95.7%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	22	23	95.7%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees in Care Management during the review period. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. HNJH had a total of 10 cases in the General Population who were in Care Management during the review period.

Table 5: Preventive Services – GP Population

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	2	3	66.7%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	2	3	66.7%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	0	1	0.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	3	7	42.9%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	2	4	50.0%
Dental needs are addressed for Enrollees (aged 21 and above)	4	7	57.1%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	2	3	66.7%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	1	1	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	1	1	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	1	1	100.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	1	1	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section includes Enrollees in Care Management during the review period (10). Four (4) cases were in Care Management prior to 11/16/21. Six (6) cases (4 New Enrollees and 2 Existing Enrollees) were new to Care Management during the review period. Community Based Care Management is reported based on files received from the MCO.

Table 6: Continuity of Care – GP Population

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	53	100	53.0%
The MCO completed a CNA during the audit period*	5	53	9.4%
For the Enrollees that completed a CNA during the audit period, the completed CNA contained all elements of the State approved CNA tool	5	5	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file	1	2	50.0%

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
A level of Care Management was determined for the Enrollee	5	5	100.0%
The Enrollee is in Community Based Care Management (CBCM). Does not include Enrollees who declined Care Management*	2	10	20.0%
A Care Plan was completed for the Enrollee that included all required components	8	10	80.0%
The Care Plan was developed within 30 days of CNA completion	4	5	80.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances or, for Existing Enrollees with no identified change in needs, Care Plan was monitored.	8	8	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	6	8	75.0%

**Not Included in aggregate score calculation*

Coordination of Services

This section includes Enrollees in Care Management during the review period (10). Four (4) cases were in Care Management prior to 11/16/21. Six (6) cases (4 New Enrollees and 2 Existing Enrollees) were new to Care Management during the review period.

Table 7: Coordination of Services – GP Population

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	9	10	90.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	10	10	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	10	10	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	10	10	100.0%

DDD Population Findings

A total of 84 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	64	84	76.2%
Initial outreach to complete a CNA was done	82	84	97.6%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	18	20	90.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	2	18	11.1%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	18	18	100.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	18	18	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	2	0.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	0	2	0.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DDD Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. HNJH had a total of 84 cases in the DDD Population.

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	41	48	85.4%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	7	7	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	7	7	100.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	29	38	76.3%

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	9	9	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	25	46	54.3%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	21	21	100.0%
Dental needs are addressed for Enrollees (aged 21 and above)	34	36	94.4%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	31	48	64.6%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	17	17	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	17	17	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	4	4	100.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees aged (9 months to 72 months)	4	4	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DDD members (84).

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	64	84	76.2%
The completed CNA contained all elements of the State approved CNA tool	64	64	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	43	64	67.2%
A level of Care Management was determined for the Enrollee	64	64	100.0%
The Enrollee is in Community Based Care Management (CBCM)*	0	84	0.0%
A Care Plan was completed for the Enrollee that included all required components	81	84	96.4%
The Care Plan was developed within 30 days of CNA Completion	63	64	98.4%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	7	11	63.6%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan	0	0	NA[2]

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

[2]NA: Not Applicable

Coordination of Services

This section applies to all DDD members (84).

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	84	84	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	78	79	98.7%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	69	69	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	5	5	100.0%
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2022 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	NA[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	NA[1]

[1]NA: Not Applicable

DCP&P Population Findings

A total of 140 files were reviewed for the DCP&P Population. (43) files were excluded from the DCP&P Population, and were not subject to further review in the following categories. HNJH had a total of 97 cases in the DCP&P Population.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	92	97	94.8%
Initial outreach to complete a CNA was done	97	97	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	5	5	100.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	0	5	0.0%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	5	5	100.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	5	5	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	0	0	NA[1]

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DCP&P Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. HNJH had a total of 97 cases in the DCP&P Population.

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	96	97	99.0%

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	87	97	89.7%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	8	10	80.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	0	0	NA[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	0	0	NA[1]
Dental needs are addressed for Enrollees (aged 21 and above)			
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	40	96	41.7%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	56	56	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	56	56	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	7	14	50.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	7	7	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	14	14	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DCP&P members (97).

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	92	97	94.8%
The completed CNA contained all elements of the State approved CNA tool	92	92	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	75	92	81.5%
A level of Care Management was determined for the Enrollee	92	92	100.0%
A Care Plan was completed for the Enrollee that included all required components	96	97	99.0%
The Care Plan was developed within 30 days of CNA Completion	90	92	97.8%

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	21	26	80.8%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	2	2	100.0%

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

Coordination of Services

This section applies to all DCP&P members (97).

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	97	97	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	95	96	99.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	93	93	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	19	19	100.0%

Limitations

No limitations are noted.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Continuity of Care (General Population) (86%)
- Coordination of Services (General Population) (98%)

- Outreach (DDD Population) (96%)
- Continuity of Care (DDD Population) (92%)
- Coordination of Services (DDD Population) (100%)

- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (95%)
- Coordination of Services (DCP&P Population) (100%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (75%)
- Outreach (General Population) (82%)
- Preventive Services (General Population) (61%)

- Preventive Services (DDD Population) (81%)

- Preventive Services (DCP&P Population) (84%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Horizon NJ Health, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key HNJH staff via WebEx held on May 10, 2023; and post audit evaluation of documentation and audit activities.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the audit review was requested by IPRO on February 10, 2023, and documentation was received from the MCOs on February 27, 2023. The documentation review occurred offsite at IPRO beginning on February 28, 2023. The audit review team was made up of Carla Zuccarello, Cynthia Steffe, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2022 to December 31, 2022.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. HNJH received an overall compliance score of 77% in 2023. In 2022, the MCO received a score of 83%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2023. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	X	X	-	-	-	-	-
CM3	-	-	X	-	X	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	X	-	X	-	-	-	X
CM7	-	-	X	-	X	-	-
CM8	-	-	X	-	X	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	-	X	-	-	-	X
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	-	X	-	-	-	X
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM19	-	X	-	-	-	X	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	25	23	7	0	4	1	3
Compliance Percentage		77%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 33.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees only). 81.8% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 69.2% - IHS was completed for the Enrollee within 45 days of Enrollment (applies to new Enrollees only). 53.8% - When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees only).

Element	Contract Language	Reviewer Comments
	management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs assessment tool.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 77.1% - For Enrollees with no CNA on file, initial outreach to complete the CNA was done. 50.0% - The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file. **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 67.2% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 81.5% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 80.0% - A Care Plan was completed for the Enrollee that included all the required components. 80.0% - The Care Plan was developed within 30 days of CNA Completion.

Element	Contract Language	Reviewer Comments
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires, and level of self-direction of the Enrollee and/or caregiver.	**In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 63.6% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances. **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 80.8% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 66.7% - The Enrollee's EPSDT exam is up to date per periodicity schedule and status is confirmed by a reliable source (aged 0 through 20). 66.7% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 0.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 42.9% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 50.0% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 57.1% - Dental needs are addressed for Enrollees (aged 21 and above).

Element	Contract Language	Reviewer Comments
		66.7% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 76.3% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 54.3% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 64.6% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 80.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 41.7% - A dental visit occurred during the review period for Enrollees (aged 1 through 20).
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 75.0% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.

Recommendations

For the General Population:

1. **CM3:** For New and Existing Enrollees, HNJH should ensure that they appropriately identify Enrollees with potential CM needs.
2. **CM6:** HNJH should ensure that an IHS is completed within 45 days of enrollment for Enrollees, and aggressive outreach should be attempted and documented when initial outreach is unsuccessful within 45 days of the Enrollee's enrollment.
3. **CM7:** HNJH should ensure that initial outreach to complete a CNA is done, and the Comprehensive Needs Assessment (CNA) is completed timely, (within 30 days following an IHS score of 5 or greater).
4. **CM8:** HNJH should ensure the Care Plan is completed within 30 days of CNA completion, and the Care Plan contains all required components.
5. **CM14:** HNJH should ensure Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity schedule and status is confirmed by a reliable source.
6. **CM14:** HNJH should ensure Enrollee's (aged 0 through 18) immunizations are up to date and immunization status is confirmed by a reliable source.
7. **CM14:** HNJH should ensure aggressive outreach attempts are documented to confirm immunization status for Enrollees (aged 0 through 18).
8. **CM14:** For Enrollees (aged 19 and above), HNJH should ensure that appropriate vaccines are administered, and aggressive outreach attempts are documented to confirm immunization status.
9. **CM14:** HNJH should ensure that dental needs are addressed for Enrollees (aged 21 and above).
10. **CM14:** HNJH should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20).
11. **CM15:** HNJH should ensure for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.

For the DDD Population:

1. **CM7:** HNJH should ensure that the Comprehensive Needs Assessment (CNA) is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM11:** HNJH should ensure the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.
3. **CM14:** HNJH should ensure that immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source.
4. **CM14:** HNJH should ensure that appropriate vaccines have been administered for Enrollees (aged 19 and above).
5. **CM14:** HNJH should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20).

For the DCP&P Population:

1. **CM7:** HNJH should ensure that the Comprehensive Needs Assessment (CNA) is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM11:** HNJH should ensure the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.
3. **CM14:** HNJH should ensure aggressive outreach attempts are documented to confirm immunization status for Enrollees (aged 0 through 18).
4. **CM14:** HNJH should ensure that a dental visit occurs during the review period for Enrollees aged (1 through 20).

IPRO
Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Horizon New Jersey Health

Review Period July 1, 2022 – June 30, 2023

February 2024

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Better healthcare, realized.

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following State guidance, Managed Care Organizations expanded face-to-face visits to all MLTSS Members and resumption of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. In addition, the NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting* was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2022 to June 30, 2023.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 135 cases for Horizon New Jersey Health (HNJH) including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS 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 MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within 45 days of MLTSS enrollment).

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

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

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 135 cases selected for Horizon New Jersey Health (HNJH), 128 Member files were reviewed and 124 were included in the results:

Description	Group C	Group D	Group E	Ancillary Group	Subtotal
Total Number of Files Reviewed	34	41	28	25	128
Exclusions	0	0	3	1	4
Number of Files included in Results	34	41	25	24	124

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits *or* Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's audit results for the combined MLTSS sample ranged from 83.4% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 1, 2022 to June 30, 2023			
Determination by Category	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	100.0%	100.0%	100.0%
Member Outreach	100.0%	85.4%	--	92.0%
Face-to-Face Visits *or* Telephonic Monitoring	97.5%	98.3%	99.0%	98.2%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	94.2%	96.2%	95.9%	95.5%
Ongoing Care Management	78.6%	85.4%	87.0%	83.4%
Gaps in Care/Critical Incidents	98.3%	98.7%	100.0%	98.9%

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

[2]Member outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 34 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). No files were excluded. All 34 files were further reviewed for compliance in 6 categories. There were 9 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJCA for the Member from OCCO.*	9	34	26.5%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	9	9	100.0%
OCCO response was received within 5 business days of the MCO request.*	8	9	88.9%
The MCO received a NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	4	9	44.4%
OCCO completed the NJ Choice Assessment which is valid during the review period.*	11	34	32.4%
The MCO completed the NJ Choice Assessment with the Member.	23	23	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	34	34	100.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	34	34	100.0%
Member is unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.[1]	23	23	100.0%
Member was offered the participant direction option.[2]	25	25	100.0%
Member chose to participate in participant direction. (excludes Members residing in CARS).*	13	25	52.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[2]	12	13	92.3%

Member had a completed and signed Interim Plan of Care (IPOC).[1]	21	23	91.3%
A cost effective analysis was completed during the review period.	34	34	100.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	34	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2]Denominator excludes Members residing in CARS

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	28	34	82.4%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	34	88.2%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	5	25	20.0%
Member was assessed for PCA services (excludes Members residing in CARS)*	19	20	95.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	15	19	78.9%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	3	19	15.8%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	33	34	97.1%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	34	34	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	34	34	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	34	34	100.0%

Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	25	25	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	25	25	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	24	25	96.0%
Member service preference levels were documented in the Back-up Plan.[1]	25	25	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	20	25	80.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	24	25	96.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	33	34	97.1%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	34	34	100.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	25	25	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	12	25	48.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	7	12	58.3%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	20	25	80.0%
Member experienced issues that impeded access to care.*	7	34	20.6%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	7	7	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	26	34	76.5%
Member required a change in Plan of Care based on an increase or reduction of services. *	8	34	23.5%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	5	8	62.5%

Member file indicates disagreement with the Plan of Care.*	0	3	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	34	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	4	5	80.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	4	5	80.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	24	25	96.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	25	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	34	34	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 41 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). No files were excluded. All 41 files were further reviewed for compliance in all 6 categories. There were 5 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an SCS tool completed.*	40	41	97.6%
Member enrolled into MLTSS on an SCS Waiver.*	40	40	100.0%
NJCA completed within 30 days of a referral to MLTSS.	0	0	N/A
The MCO completed the NJ Choice Assessment at a face-to-face visit.	41	41	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	35	41	85.4%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	41	41	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	41	41	100.0%
Member had PPP services in place prior to MLTSS enrollment (excludes Members in CARS).*	0	36	0.0%
Member was offered the participant direction option.[1]	36	36	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	16	36	44.4%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	14	16	87.5%
Member had a completed and signed Interim Plan of Care (IPOC).	40	41	97.6%
A cost effective analysis was completed during the review period.	41	41	100.0%

The Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	41	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	37	41	90.2%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	36	41	87.8%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	1	36	2.8%
Member was assessed for PCA services (excludes Members residing in CARS).*	25	35	71.4%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	22	25	88.0%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	7	25	28.0%
Member was re-assessed for PCA due to changes in condition.[1]	7	7	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	41	41	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	41	41	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	41	41	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	41	41	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	36	36	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	36	36	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	36	36	100.0%

Member service preference levels were documented in the Back-up Plan.[1]	36	36	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	36	36	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	36	36	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	41	41	100.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	41	41	100.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	34	36	94.4%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	14	34	41.2%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	5	15	33.3%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	32	36	88.9%
Member experienced issues that impeded access to care.*	8	41	19.5%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	7	8	87.5%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	35	41	85.4%
Member required a change in Plan of Care based on an increase or reduction of services.*	16	41	39.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	14	16	87.5%
Member file indicates disagreement with the Plan of Care.*	0	2	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	41	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	8	11	72.7%
Member was discharged to his/her own home and in home services were in place in a timely manner.	9	11	81.8%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	35	36	97.2%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	36	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	41	41	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 28 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). 3 files were excluded. The Member Outreach category is not assessed for Group E, as these Members are not new to MLTSS. All 25 files were reviewed for compliance in 5 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	25	25	100.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	25	25	100.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	25	25	100.0%
Member had PPP services in place prior to review period (excludes Members residing in CARS).*	3	23	13.0%
Member was offered the participant direction option.[1]	20	20	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	1	20	5.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	24	25	96.0%
A cost effective analysis was completed during the review period.	25	25	100.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	1	25	4.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	1	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
N/A: Not Applicable

Ongoing Plan of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	25	25	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	23	25	92.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	24	25	96.0%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	3	23	13.0%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	25	25	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	23	23	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	23	23	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	22	23	95.7%
Member service preference levels were documented in the Back-up Plan.[1]	23	23	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	23	23	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	22	23	95.7%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	24	25	96.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	22	23	95.7%

Members who were identified as having a positive risk.*	8	22	36.4%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	4	8	50.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.[2]	6	14	57.1%[2]

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS

[2]Percentage rate is indicative of compliant cases

Ongoing Care Management	N	D	Rate
Member experienced issues that impeded access to care.*	3	25	12.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	3	3	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	20	25	80.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	2	25	8.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	2	50.0%
Member file indicated a disagreement with the Plan of Care.*	0	1	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	7	7	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	7	7	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	2	2	100.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	23	23	100.0%
Member reported a gap in service delivery (excludes Members in CARS).*	2	23	8.7%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment, #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change in Member condition), #10 (Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan, and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2022-2023 audit findings. Overall, HNJH's audit results ranged from 88.9% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	28	34	82.4%
	Group D	37	41	90.2%
	Group E[4]			
	Ancillary C	5	6	83.3%
	Ancillary D	18	18	100.0%
	Total	88	99	88.9%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	25	25	100.0%
	Total	25	25	100.0%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	Group C	0	0	N/A
	Group D	0	0	N/A
	Group E	2	2	100.0%
	Total	2	2	100.0%
#10. Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment.	Group C	33	34	97.1%
	Group D	41	41	100.0%
	Group E	25	25	100.0%
	Total	99	100	99.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	34	34	100.0%
	Group D	41	41	100.0%
	Group E	25	25	100.0%
	Total	100	100	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan.[3]	Group C	25	25	100.0%
	Group D	36	36	100.0%
	Group E	23	23	100.0%
	Total	84	84	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	34	34	100.0%
	Group D	41	41	100.0%
	Group E	25	25	100.0%
	Total	100	100	100.0%

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

[2]Members who did not have a documented change in condition during the study period are excluded from this measure
[3]Members residing in a community alternative residential setting (CARS) are excluded from this measure
[4]Group E Members are excluded from this measure as they are not new to MLTSS
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure
N/A: Not applicable

Discussion

Limitations

COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. The MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5). Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could only be evaluated for those Members not enrolled through the SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below. Opportunities for Improvement for elements at the group level with a score below 86% are provided for the following categories: Member Outreach and Ongoing Care Management.

Assessment

Across all three groups, the MCO had a combined score of 100.0% in the Assessment category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Member Outreach

Across groups, the MCO had a combined score of 92.0% in the Member Outreach category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	85.4%
Group E[1]	
Combined	92.0%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level *with a score less than 86%* in the *Member Outreach* category include the following:

- Group D: HNJH should ensure that initial outreach to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) occurs within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits or Telephonic Monitoring

Across all three groups, the MCO had a combined score of 98.2% in the Face-to-Face Visits *or* Telephonic Monitoring category.

Group	7/1/22 to 6/30/23
Group C	97.5%
Group D	98.3%
Group E	99.0%
Combined	98.2%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 95.5% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/22 to 6/30/23
Group C	94.2%
Group D	96.2%
Group E	95.9%
Combined	95.5%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 83.4% in the Ongoing Care Management category.

Group	7/1/22 to 6/30/23
Group C	78.6%
Group D	85.4%
Group E	87.0%
Combined	83.4%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Ongoing Care Management* category include the following:

- Group C: HNJH should ensure that the Member has services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation). HNJH should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). HNJH should ensure for Member files that indicate a change from the initial Plan of Care, the Plan of Care is updated to reflect those changes, and a copy is provided to the Member and/or authorized representative. For Members who are discharged to an HCBS setting, the Care Manager should conduct an onsite review within ten (10) days and ensure that in home services are in place in a timely manner.

- Group D: HNJH should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). For Members who are discharged to an HCBS setting, the Care Manager should conduct an onsite review within ten (10) days and ensure that in home services are in place in a timely manner.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 98.9% in the Gaps in Care/Critical Incidents category.

Group	7/1/22 to 6/30/23
Group C	98.3%
Group D	98.7%
Group E	100.0%
Combined	98.9%

Performance Measures

Overall, HNJH scored above 86% in all seven (7) Performance Measures.

Opportunities for Improvement at the group level in MLTSS Performance Measures *with a score less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- Group C: HNJH should ensure that a copy of the completed initial Plan of Care is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2023 Annual Assessment Review of Care Management
Horizon New Jersey Health

Review Period - July 1, 2022 to June 30, 2023
December 2023

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jersey Health (HNJH) as evidence of compliance of the standards under review; interviews with key HNJH staff (held via Teams meeting on November 29, 2023) and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on July 25, 2023, and received from the MCOs on August 7, 2023. The documentation review occurred offsite at IPRO beginning on August 8, 2023. The IPRO review team consisted of Carla Zuccarello, Cynthia Santangelo, Rachel Fahey, and Lois Heffernan. The Care Management assessment covered the period from July 1, 2022 to June 30, 2023. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2023 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. HNJH received an overall compliance score of 100% in 2023. In 2022, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Horizon NJ Health

November 2023

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1st through June 30th. Due to COVID-19 pandemic, the prior review period was from January 1, 2021 through August 14, 2021, during which time face to face visits were suspended and access to Nursing facilities was restricted. The review period for this audit was August 15, 2021 through August 31, 2022, during which time DMAHS issued the MCO Care Management Visit Guidance. Effective November 16, 2021, MCO Care Managers were to expand face to face visits to all MLTSS Members and resume completion of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities, allowing telephonic visits for Members who refused an in person visit, and for Nursing Facilities with visitation protocols restricting Care Manager access. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the *MCO Contracts* in *Article 9* from the *State of New Jersey DHS, DMAHS MCO Contract* to provide services dated July 2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022 to coincide with the State's *extension deadline for return to field activities*, disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to a NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from this

audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

Capitation Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Horizon NJ Health (HNJH), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on August 31, 2022.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on August 31, 2022.
- The Member cannot have been enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (August 31, 2022).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from August 15, 2021 to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from August 15, 2021 to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files, and uploading the files to IPRO's File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a 4-week period. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for HNJH, 102 Member files were reviewed and included in the results pertaining to the Plan of Care for institutional settings. Two (2) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" were not included in scoring. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Tables 4–7**). A total of 100 files were reviewed for requirements regarding the Facility and MCO Plan of Care (**Table 4**), MLTSS Initial Plan of Care and Ongoing Plans of Care (**Table 5**), Transition Planning (**Table 6**), and Reassessment of the Plan of Care and Critical Incident Reporting (**Table 7**). Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–7**).

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	98	100	98.0%
Documented review of the Facility Plan of Care by the Care Manager.	98	98	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	98	98	100.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	10	10	100.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	100	100	100.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	100	100	100.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	100	100	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	100	100	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	100	100	100.0%
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.	11	13	84.6%

Table 6: Transition Planning

Transition Planning	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	6	100	6.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	5	100	5.0%
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	100	100	100.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	89	100	89.0%
Members requiring coordination of care had coordination of care by the Care Manager.	97	100	97.0%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission.	98	100	98.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	97	100	97.0%
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.	100	100	100.0%
Care Manager reviewed the Member's rights and responsibilities.	94	100	94.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	94	100	94.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	96	100	96.0%

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for HNJH, 100 Member files were reviewed and included in the results. Rates were calculated for state-requirement–specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 8**).

Table 8: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period	99
Group 2[1]	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	1
Group 3[1]	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	1
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

[1]Represents the same Member in Group 2 and Group 3

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Table 9** and **Table 10**). Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 1 file was reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4; **Table 9**). Rates were calculated to profile NF/SCNF Members that transitioned to HCBS.

Table 9: NF/SCNF Members Transitioned to HCBS

Transition to HCBS	N	D	Rate
NJCA was completed to assess the Member's needs prior to discharge from a NF/SCNF.	1	1	100.0%
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	1	1	100.0%
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	100.0%
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	1	1	100.0%
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer.	1	1	100.0%
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	1	1	100.0%
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	1	1	100.0%

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 1 file was reviewed for Members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4; **Table 10**). Rates were calculated to profile HCBS Members that transitioned to a NF/SCNF.

Table 10: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member had a person-centered transition plan on file.	1	1	100.0%
Member participated in a therapeutic leave.	0	1	0.0%
Care Manager completed a risk management agreement for the Member when indicated.	0	0	N/A
Member was admitted to NF/SCNF directly from an acute facility.	0	1	0.0%
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.**	1	1	100.0%

N/A: not applicable.

The expansion of the NF audit components included evaluating the NF/SCNF population on the MLTSS PMs. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings are presented in **Table 11**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #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), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations (**Table 11)**.

Table 11: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	10	10	100.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[2]	94	100	94.0%
#9a. Member's Plan of Care is amended based on change of Member condition[3]	11	13	84.6%
#11. Plans of Care developed using "person-centered principles"[4]	100	100	100.0%
#16. Member training on identifying/reporting critical incidents	96	100	96.0%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an Initial Plan of Care.
[2] 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 and the end of the study period.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] 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 Plan of Care.

Discussion

Limitations

Results are limited as the same (1) Member was identified in both Group 2 (Members who transitioned from a NF/SCNF to HCBS), and Group 3 (Members who transitioned from HCBS to the NF/SCNF); in addition, there was an absence of Members in Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS), during the review period.

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–7**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (98.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (100.0%)
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS) (100.0%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (100.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (100.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (89.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (97.0%)
- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (98.0%)

- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (97.0%)
- 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 (100.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (94.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (94.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (96.0%)

Opportunities for Improvement for Audit Elements

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an institutional setting (**Tables 4–7**):

- 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 (84.6%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (6.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (5.0%)

Recommendations for Audit Elements

HNJH's MLTSS Care Managers should ensure for Member's who experience a significant change in condition, the Plan of Care is updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. Care Managers should participate in at least one Interdisciplinary Team (IDT) meeting during the review period. Care Managers should ensure Members are identified for transfer to HCBS, and offer options, including transfer to the community.

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (**Table 11**):

- #9a. Member's Plan of Care is amended based on change of Member condition (84.6%)

Recommendations for MLTSS Performance Measures

HNJH's MLTSS Care Managers should ensure that the Member's Plan of Care is amended when a Member experiences a significant change in condition.

Appendix E: UHCCP 2023 Core Medicaid and MLTSS Care Management Audits

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
UnitedHealthcare Community Plan

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

November 2023

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MCO Care Management Chart Audit

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, NJ Care Management Workbook, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology, as shown in Table 1, resulted in the selection of 212 cases for UnitedHealthcare Community Plan (UHCCP), including a 10% oversample for the General Population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) was selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (24). All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (78).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. AND (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499). Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2022	>= 3 months as of 12/31/2022	>= 3 months and < 18 years as of 12/31/2022
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2022 and 7/1/2022	Initial enrollment between 1/1/2022 and 12/31/2022	Initial enrollment between 1/1/2022 and 12/31/2022
• Existing Enrollees	Enrolled prior to 1/1/2022		
Current Enrollment	Enrolled as of 12/31/2022	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2022 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP 2023 CM Audit results for the review period 1/1/2022 to 12/31/2022 ranged from 57% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=24)	DCP&P (n=41)
Identification[1]	57%		
Outreach	100%	100%	100%
Preventive Services	73%	71%	83%
Continuity of Care	87%	95%	96%
Coordination of Services	96%	100%	98%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 25 Enrollees were New Enrollees and 75 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	GP Population		
	Numerator	Denominator	Rate
Enrollee has an IHS on file completed during the audit period (1/1/22 to 12/31/22) (applies to New Enrollees only)*	6	25	24.0%
IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only)	6	6	100.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS)*	5	19	26.3%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only)	8	14	57.1%
Enrollees identified by the Plan as having potential Care Management needs (applies to New Enrollees only where IHS score is less than 5 or no IHS on file)*	5	20[1]	25.0%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to New Enrollees only)	8	15	46.7%[2]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2021 or existing Enrollees newly enrolled in CM during the review period)*	17	75	22.7%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to Existing Enrollees enrolled prior to 11/16/2021)	26	58	55.2%[2]
Enrollees identified by the Plan as having potential Care Management needs (applies to Existing Enrollees not enrolled in Care Management prior to 11/16/2021 or during the review period).*	11	32	34.4%

**Not Included in aggregate score calculation*

[1]Denominator includes 19 (nineteen) cases with no IHS on file and 1 (one) case with an IHS score less than 5

[2] Percentage rate is indicative of an inverse percentage – higher score is indicative of positive performance

Outreach

This section applies only to Existing Enrollees not in Care Management prior to 11/16/21 where the MCO identified need, and to New Enrollees where the MCO identified need based on an IHS score greater than or equal to 5, or through other means where no IHS was on file or the IHS score was less than 5.

Table 4: Outreach – GP Population

Outreach	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	26	100	26.0%
The MCO completed a CNA during the audit period*	6	26	23.1%
For Enrollees with no CNA on file, initial outreach to complete a CNA was done	20	20	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 30 days of the identification of CM needs	20	20	100.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	8	20	40.0%
Aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	17	20	85.0%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	16	17	94.1%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	4	8	50.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	4	8	50.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees in Care Management during the review period. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. United had a total of 19 cases in the General Population who were in Care Management during the review period.

Table 5: Preventive Services – GP Population

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	4	4	100.0%

Preventive Services	GP Population		
	Numerator	Denominator	Rate
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	0	NA[1]
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	0	NA[1]
The Enrollee's immunizations are up to date for Enrollees aged (0 through 18) and immunization status is confirmed by a reliable source	2	4	50.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	2	2	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	6	15	40.0%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	6	9	66.7%
Dental needs are addressed for Enrollees (aged 21 and above)	15	15	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	3	4	75.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	1	1	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	1	1	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	0	NA[1]
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	0	0	NA[1]

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

Continuity of Care

This section includes Enrollees in Care Management during the review period (19). Twelve (12) cases were in Care Management prior to 11/16/21. Seven (7) cases (2 New Enrollees and 5 Existing Enrollees) were new to Care Management during the review period. Community Based Care Management is reported based on files received from the MCO.

Table 6: Continuity of Care – GP Population

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	26	100	26.0%
The MCO completed a CNA during the audit period*	6	26	23.1%
For the Enrollees that completed a CNA during the audit period, the completed CNA contained all elements of the State approved CNA tool	6	6	100.0%

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file	2	2	100.0%
A level of Care Management was determined for the Enrollee	5	6	83.3%
The Enrollee is in Community Based Care Management (CBCM). Does not include Enrollees who declined Care Management*	0	19	0.0%
A Care Plan was completed for the Enrollee that included all required components	14	19	73.7%
The Care Plan was developed within 30 days of CNA completion	6	6	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances or, for Existing Enrollees with no identified change in needs, Care Plan was monitored.	11	12	91.7%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%

**Not Included in aggregate score calculation*

Coordination of Services

This section includes Enrollees in Care Management during the review period (19). Twelve (12) cases were in Care Management prior to 11/16/21. Seven (7) cases (2 New Enrollees and 5 Existing Enrollees) were new to Care Management during the review period.

Table 7: Coordination of Services – GP Population

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	19	19	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	18	18	100.0%

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	7	7	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	9	11	81.8%

DDD Population Findings

A total of 24 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	19	24	79.2%
Initial outreach to complete a CNA was done	24	24	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	5	5	100.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	1	5	20.0%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	3	5	60.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	3	3	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	1	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	1	1	100.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DDD Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. United had a total of 24 cases in the DDD Population.

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	12	13	92.3%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	2	8	25.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	6	6	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	5	16	31.3%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	10	11	90.9%
Dental needs are addressed for Enrollees (aged 21 and above)	9	11	81.8%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	8	13	61.5%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	5	5	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	5	5	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	1	1	100.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	1	1	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DDD members (24).

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	19	24	79.2%
The completed CNA contained all elements of the State approved CNA tool	19	19	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	14	19	73.7%
A level of Care Management was determined for the Enrollee	19	19	100.0%

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The Enrollee is in Community Based Care Management (CBCM)*	16	24	66.7%
A Care Plan was completed for the Enrollee that included all required components	24	24	100.0%
The Care Plan was developed within 30 days of CNA Completion	19	19	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	3	3	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	0	0	NA[2]

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

[2]NA: Not Applicable

Coordination of Services

This section applies to all DDD members (24).

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	24	24	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	13	13	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	4	4	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed	4	4	100.0%
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2022 the Care Manager documented evidence of follow up within 30 days of discharge	1	1	100.0%
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	NA[1]

[1]NA: Not Applicable

DCP&P Population Findings

A total of 78 files were reviewed for the DCP&P Population. (37) files were excluded from the DCP&P Population and were not subject to further review in the following categories. UHCCP had a total of 41 cases in the DCP&P Population.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	41	41	100.0%
Initial outreach to complete a CNA was done	41	41	100.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	0	0	NA[1]
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	0	0	NA[1]
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	0	0	NA[1]
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined to Care Management*	0	0	NA[1]

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DCP&P Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. United had a total of 41 cases in the DCP&P Population.

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	41	41	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	0	NA[1]
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	0	NA[1]

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	25	41	61.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	16	16	100.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	0	0	NA[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	0	0	NA[1]
Dental needs are addressed for Enrollees (aged 21 and above)			
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	22	35	62.9%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	13	13	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	13	13	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	7	7	100.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	7	7	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DCP&P members (41).

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	41	41	100.0%
The completed CNA contained all elements of the State approved CNA tool	41	41	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	33	41	80.5%
A level of Care Management was determined for the Enrollee	41	41	100.0%
A Care Plan was completed for the Enrollee that included all required components	41	41	100.0%
The Care Plan was developed within 30 days of CNA Completion	41	41	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	3	3	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan	0	0	NA[2]

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

[2]NA: Not Applicable

Coordination of Services

This section applies to all DCP&P members (41).

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	41	41	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	36	36	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	13	15	86.7%
For Enrollees who were hospitalized, adequate discharge planning was performed	4	4	100.0%

Limitations

Audit results for the DDD and DCP&P Populations should be considered cautiously due to the low sample size of 24 and 41 respectively.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (100%)
- Continuity of Care (General Population) (87%)
- Coordination of Services (General Population) (96%)

- Outreach (DDD Population) (100%)
- Continuity of Care (DDD Population) (95%)
- Coordination of Services (DDD Population) (100%)

- Outreach (DCP&P Population) (100%)
- Continuity of Care (DCP&P Population) (96%)
- Coordination of Services (DCP&P Population) (98%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (57%)
- Preventive Services (General Population) (73%)
- Preventive Services (DDD Population) (71%)
- Preventive Services (DCP&P Population) (83%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by UnitedHealthcare Community Plan, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key UHCCP staff via WebEx held on May 10, 2023; and post audit evaluation of documentation and audit activities.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the audit review was requested by IPRO on February 10, 2023, and documentation was received from the MCOs on February 27, 2023. The documentation review occurred offsite at IPRO beginning on February 28, 2023. The audit review team was made up of Eileen Plotkin, Juana Torres and Lauren Dudas. The Care Management assessment covered the period from January 1, 2022 to December 31, 2022.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. UHCCP received an overall compliance score of 80% in 2023. In 2022, the MCO received a score of 73%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2023. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P). **Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	-	-	X	-	X	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	-	X	-	X	-	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	-	X	-	-	-	X	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-		
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM19	-	X	-	-	-	X	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-		-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	22	24	6	0	6	2	0
Compliance Percentage		80%					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 81.8% - For Enrollees who were hospitalized, adequate discharge planning was performed.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 46.7% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees only). 55.2% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 57.1% - When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done

Element	Contract Language	Reviewer Comments
	for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	within 45 days of the Enrollee's enrollment (applies to New Enrollees only).
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO's assessment tool.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 83.3% - A level of Care Management was determined for the Enrollee. **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 73.7% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 80.5% - The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 73.7% - A Care Plan was completed for the Enrollee that included all required components.

Element	Contract Language	Reviewer Comments
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 50.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 40.0% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 66.7% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 75.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 25.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 31.3% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 81.8% - Dental needs are addressed for Enrollees (aged 21 and above). 61.5% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 61.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source.

Element	Contract Language	Reviewer Comments
		62.9% - A dental visit occurred during the review period for Enrollees (aged 1 through 20).

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM13	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.

Recommendations

For the General Population:

1. **CM2:** UHCCP should ensure that adequate discharge planning is performed for Enrollees who are hospitalized.
2. **CM3:** For New and Existing Enrollees, UHCCP should ensure that they appropriately identify Enrollees with potential CM needs.
3. **CM6:** UHCCP should ensure that when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.
4. **CM7:** UHCCP should ensure that a level of Care Management is determined for the Enrollee.
5. **CM8:** UHCCP should ensure that a Care Plan is completed for the Enrollee that includes all required components.
6. **CM14:** UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source.
7. **CM14:** For Enrollees (aged 19 and above), UHCCP should ensure that appropriate vaccines have been administered, and aggressive outreach attempts were documented to confirm immunization status.
8. **CM14:** UHCCP should ensure that a dental visit occurred during the review period for Enrollees (aged 1 through 20).

For the DDD Population:

1. **CM7:** UHCCP should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment).
2. **CM14:** UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source.
3. **CM14:** UHCCP should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above).
4. **CM14:** UHCCP should ensure that dental needs are addressed for Enrollees (aged 21 and above).
5. **CM14:** For Enrollees (aged 1 through 20), UHCCP should ensure that a dental visit occurs during the review period.

For the DCP&P Population:

1. **CM7:** UHCCP should ensure the Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).
2. **CM14:** UHCCP should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source.
3. **CM14:** For Enrollees (aged 1 through 20), UHCCP should ensure that a dental visit occurs during the review period.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
UnitedHealthcare Community Plan of New Jersey

Review Period July 1, 2022 – June 30, 2023

February 2024

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following State guidance, Managed Care Organizations expanded face-to-face visits to all MLTSS Members and resumption of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. In addition, the NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting* was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2022 to June 30, 2023.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 135 cases for UnitedHealthcare Community Plan of New Jersey (UHCCP) including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS 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 MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within 45 days of MLTSS enrollment).

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

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

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 135 cases selected for UnitedHealthcare Community Plan (UHCCP), 129 Member files were reviewed and 121 were included in the results:

Description	Group C	Group D	Group E	Ancillary Group	Subtotal
Total Number of Files Reviewed	10	65	29	25	129
Exclusions	3	0	4	1	8
Number of Files included in Results	7	65	25	24	121

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits *or* Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's audit results for the combined MLTSS sample ranged from 34.7% to 89.4% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 1, 2022 to June 30, 2023			
Determination by Category	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	84.0%	96.0%	89.4%
Member Outreach	42.9%	33.8%	--	34.7%
Face-to-Face Visits or Telephonic Monitoring	75.8%	79.0%	87.5%	80.7%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	80.9%	78.8%	84.8%	80.5%
Ongoing Care Management	73.7%	54.0%	39.4%	53.5%
Gaps in Care/Critical Incidents	76.9%	87.0%	83.3%	85.4%

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

[2]Member outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 10 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). 3 files were excluded. All 7 files were further reviewed for compliance in 6 categories. There was 1 Member residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJCA for the Member from OCCO. *	0	7	0.0%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO). *	0	0	N/A
OCCO response was received within 5 business days of the MCO request. *	0	0	N/A
The MCO received a NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current. *	0	0	N/A
OCCO completed the NJ Choice Assessment which is valid during the review period. *	0	7	0.0%
The MCO completed the NJ Choice Assessment with the Member.	7	7	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	3	7	42.9%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits. *	5	7	71.4%
Member is unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member has a legal guardian. *	2	2	100.0%
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager. *	2	2	100.0%
Member or authorized representative refused to participate in any face-to-face visits.*	0	2	0.0%
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit. *	0	2	0.0%
Options Counseling was provided to the Member.[1]	7	7	100.0%
Member was offered the participant direction option.[2]	6	6	100.0%
Member chose to participate in participant direction. (excludes Members residing in CARS).*	4	6	66.7%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[2]	1	4	25.0%

Member had a completed and signed Interim Plan of Care (IPOC).[1]	4	7	57.1%
A cost-effective analysis was completed during the review period.	7	7	100.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT). *	2	7	28.6%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	2	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2]Denominator excludes Members residing in CARS

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	1	7	14.3%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	7	7	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS). *	0	6	0.0%
Member was assessed for PCA services (excludes Members residing in CARS). *	3	6	50.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	3	3	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS) *	1	3	33.3%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	7	7	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	7	7	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	7	7	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	7	7	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	3	6	50.0%

Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	3	3	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	3	3	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	3	3	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	1	3	33.3%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	5	6	83.3%
Member file included a member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	4	7	57.1%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	5	7	71.4%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	6	6	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	4	6	66.7%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	3	4	75.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	6	6	100.0%
Member experienced issues that impeded access to care.*	0	7	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	3	7	42.9%
Member required a change in Plan of Care based on an increase or reduction of services. *	1	7	14.3%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	1	0.0%
Member file indicates disagreement with the Plan of Care. *	0	1	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours. *	0	7	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	2	2	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	2	2	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in Community Alternative Residential Settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	5	6	83.3%
Member reported a gap in service delivery (excludes Members residing in CARS)*	0	6	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	5	7	71.4%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 65 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). No files were excluded. All 65 files were further reviewed for compliance in all 6 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an SCS tool completed. *	51	65	78.5%
Member enrolled into MLTSS on an SCS Waiver. *	40	51	78.4%
NJCA completed within 30 days of a referral to MLTSS.	0	11	0.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	63	64	98.4%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	22	65	33.8%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits. *	60	65	92.3%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian. *	4	5	80.0%
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager. *	4	4	100.0%
Member or authorized representative refused to participate in any face-to-face visits.*	1	5	20.0%
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit. *	1	5	20.0%
Options Counseling was provided to the Member.	40	63	63.5%
Member had PPP services prior to MLTSS enrollment (excludes Members residing in CARS).*	17	64	26.6%
Member was offered the participant direction option.[1]	46	47	97.9%
Member chose to participate in participant direction (excludes Members residing in CARS). *	13	46	28.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	2	14	14.3%
Member had a completed and signed Interim Plan of Care (IPOC).	53	63	84.1%

A cost effective analysis was completed during the review period.	58	65	89.2%
The Member reached or exceeded 85% of the annual cost threshold (ACT). *	0	58	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	6	65	9.2%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	63	65	96.9%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	4	64	6.2%
Member was assessed for PCA services (excludes Members residing in CARS).*	16	60	26.7%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	7	16	43.8%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	3	16	18.8%
Member was re-assessed for PCA due to changes in condition or living arrangements.[1]	3	3	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	63	63	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	63	65	96.9%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	63	63	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	37	63	58.7%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	44	64	68.8%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	44	44	100.0%

Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	44	44	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	44	44	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	16	44	36.4%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	54	64	84.4%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	43	65	66.2%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	53	65	81.5%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	62	64	96.9%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	56	62	90.3%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	45	56	80.4%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45-calendar day standard and are not included in this calculation).[1]	63	64	98.4%
Member experienced issues that impeded access to care. *	0	65	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	12	65	18.5%
Member required a change in Plan of Care based on an increase or reduction of services. *	6	65	9.2%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	6	0.0%
Member file indicates disagreement with the Plan of Care.*	0	6	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours. *	0	65	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	7	12	58.3%
Member was discharged to his/her own home and in home services were in place in a timely manner.	5	12	41.7%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	1	4	25.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in Community Alternative Residential Settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	61	64	95.3%
Member reported a gap in service delivery (excludes Members residing in CARS). *	2	64	3.1%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	2	50.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	52	65	80.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 29 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). 4 files were excluded. The Member Outreach category is not assessed for Group E, as these Members are not new to MLTSS. All 25 files were reviewed for compliance in 5 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	24	25	96.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	24	25	96.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits. *	21	25	84.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian. *	4	4	100.0%
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager. *	4	4	100.0%
Member or authorized representative refused to participate in any face-to-face visits. *	0	4	0.0%
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	4	0.0%
Options Counseling was provided to the Member.	15	24	62.5%
Member had PPP services prior to review period (excludes Members residing in CARS).*	9	23	39.1%
Member was offered the participant direction option.[1]	14	14	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	1	14	7.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	23	24	95.8%
A cost-effective analysis was completed during the review period.	24	25	96.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT). *	0	24	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	22	23	95.7%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	24	25	96.0%
Member required another PCA assessment due to changes in condition. (excludes Members residing in CARS) *	0	23	0.0%
Member was re-assessed for PCA due to changes in condition.[1]	0	0	N/A
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	23	23	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	24	25	96.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	24	24	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	15	24	62.5%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	15	23	65.2%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	15	15	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	15	15	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	15	15	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	4	15	26.7%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	17	23	73.9%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	18	25	72.0%

The Care Manager educated the Member on how to file a grievance and/or an appeal.	20	25	80.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	20	23	87.0%
Members who were identified as having a positive risk. *	16	20	80.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	12	16	75.0%[2]
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.	0	4	100.0%[2]

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member experienced issues that impeded access to care. *	1	25	4.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	6	25	24.0%
Member required a change in Plan of Care based on an increase or reduction of services. *	1	25	4.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	1	1	100.0%
Member file indicated a disagreement with the Plan of Care. *	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours. *	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	2	3	66.7%
Member was discharged to his/her own home and in home services were in place in a timely manner.	3	3	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in Community Alternative Residential Settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	21	23	91.3%
Member reported a gap in service delivery (excludes Members in CARS) *	0	23	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	19	25	76.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment, #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change in Member condition), #10 (Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan, and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2022-2023 audit findings. Overall, UHCCP's audit results ranged from 13.5% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	1	7	14.3%
	Group D	6	65	9.2%
	Group E[4]			
	Ancillary C	0	1	0.0%
	Ancillary D	6	23	26.1%
	Total	13	96	13.5%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	22	24	91.7%
	Total	22	24	91.7%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	Group C	1	1	100.0%
	Group D	1	4	25.0%
	Group E	0	0	N/A
	Total	2	5	40.0%
#10. Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment.	Group C	7	7	100.0%
	Group D	63	63	100.0%
	Group E	23	23	100.0%
	Total	93	93	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	7	7	100.0%
	Group D	37	63	58.7%
	Group E	15	24	62.5%
	Total	59	94	62.8%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan.[3]	Group C	3	6	50.0%
	Group D	44	64	68.8%
	Group E	15	23	65.2%
	Total	62	93	66.7%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	5	7	71.4%
	Group D	52	65	80.0%
	Group E	19	25	76.0%
	Total	76	97	78.4%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current MCO Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Members who did not have a documented change in condition during the study period are excluded from this measure
[3]Members residing in a community alternative residential setting (CARS) are excluded from this measure
[4]Group E Members are excluded from this measure as they are not new to MLTSS
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure
N/A: Not Applicable

Discussion

Limitations

COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. The MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5). Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could only be evaluated for those Members not enrolled through the SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below. Opportunities for Improvement for elements at the group level with a score below 86% are provided for the following categories: Assessment, Member Outreach, Face-to Face Visits or Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents.

Assessment

Across all three groups, the MCO had a combined score of 89.4% in the Assessment category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	84.0%
Group E	96.0%
Combined	89.4%

Opportunities for Improvement for elements at the group level *with a score less than 86%* in the *Assessment* category include the following:

- Group D: UHCCP should ensure that the NJCA is completed within 30 days of a referral to MLTSS.

Member Outreach

Across groups, the MCO had a combined score of 34.7% in the Member Outreach category.

Group	7/1/22 to 6/30/23
Group C	42.9%
Group D	33.8%
Group E[1]	--
Combined	34.7%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Member Outreach* category include the following:

- Group C: UHCCP should ensure that Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

- Group D: UHCCP should ensure that Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits or Telephonic Monitoring

Across all three groups, the MCO had a combined score of 80.7% in the Face-to-Face Visits *or* Telephonic Monitoring category.

Group	7/1/22 to 6/30/23
Group C	75.8%
Group D	79.0%
Group E	87.5%
Combined	80.7%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Face-to-Face Visits* or *Telephonic Monitoring* category include the following:

- Group C: UHCCP should ensure that Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion. UHCCP should ensure that Member has a completed and signed Interim Plan of Care (IPOC). UHCCP should ensure that Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.

- Group D: UHCCP should ensure that Options Counseling was provided to the Member. UHCCP should ensure that Members who selected the option of participant direction, application packages were submitted within

thirty (30) business days of completion. UHCCP should ensure that Member had a completed and signed Interim Plan of Care (IPOC).

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 80.5% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/22 to 6/30/23
Group C	80.9%
Group D	78.8%
Group E	84.8%
Combined	80.5%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category* include the following*:*

- Group C: UHCCP should ensure that Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program. UHCCP should ensure that Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form. UHCCP should ensure that Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis. UHCCP should ensure that there is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period. UHCCP should ensure that Member file included a member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them. UHCCP should ensure that the Care Manager educates the Member on how to file a grievance and/or an appeal. UHCCP should ensure that Members who were identified as having a positive risk, have a signed/verbally acknowledged Risk Management Agreement with all components.

- Group D: UHCCP should ensure that Member had a completed, signed/verbally acknowledged initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program. UHCCP should ensure that Member was assessed for PCA services within 45 days of enrollment into MLTSS. UHCCP should ensure that Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care. UHCCP should ensure that Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form. UHCCP should ensure that Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis. UHCCP should ensure that there is documentation that the Care Manager counseled the Member on disaster/emergency planning during the

review period. UHCCP should ensure that Member file included a member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them. UHCCP should ensure that the Care Manager educates the Member on how to file a grievance and/or an appeal. UHCCP should ensure that Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.

- Group E: UHCCP should ensure that Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care. UHCCP should ensure that Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form. UHCCP should ensure that Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis. UHCCP should ensure that there is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.
  UHCCP should ensure that Member file included a member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.
  UHCCP should ensure that The Care Manager educated the Member on how to file a grievance and/or an appeal. UHCCP should ensure that Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.

Ongoing Care Management

Across all three groups, the MCO had a combined score of 53.5% in the Ongoing Care Management category.

Group	7/1/22 to 6/30/23
Group C	73.7%
Group D	54.0%
Group E	39.4%
Combined	53.5%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Ongoing Care Management* category include the following:

- Group C: UHCCP should ensure that Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). UHCCP should ensure Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.

- Group D: UHCCP should ensure that Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). UHCCP should ensure that Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care. UHCCP should ensure that For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge. UHCCP should ensure that Member was discharged to his/her own home and in home services were in place in a timely manner. UHCCP should ensure that Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.

- Group E: UHCCP should ensure that Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). UHCCP should ensure that for Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 85.4% in the Gaps in Care/Critical Incidents category.

Group	7/1/22 to 6/30/23
Group C	76.9%
Group D	87.0%
Group E	83.3%
Combined	85.4%

Opportunities for Improvement for elements at the group level *for scores less than 86%* in the *Gaps in Care/Critical Incidents* category include the following:

- Group C: UHCCP should ensure Members receiving MLTSS services and not residing in Community Alternative Residential Settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member. UHCCP should ensure Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.

- Group E: UHCCP should ensure that Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.

Performance Measures

Overall, UHCCP scored below 86% in 5 of the seven (7) Performance Measures.

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.
- #9a. Member's Plan of Care is amended based on change in Member condition.
- #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.
- #16. Member training on identifying/reporting critical incidents.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

PM #8: Initial Plan of Care established within 45 days of enrollment into MLTSS/HCBS.

- Group C and Group D: UHCCP should ensure that a copy of the initial Plan of Care is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment.

PM #9a: Member's Plan of Care is amended based on change in Member condition.

- Group D: UHCCP should ensure that Member's Plan of Care is amended based on change in Member condition.

PM #11: Plans of Care developed using "Person-Centered Principles."

- Group D and Group E: UHCCP should ensure that the Plans of Care developed are using "Person-Centered Principles." Plans of Care should contain evidence all options were reviewed with the Member and/or authorized representative and is signed by the Member and/or authorized representative.

PM #12: MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan.

- Group C, Group D, and Group E: UHCCP should ensure that MLTSS Home and Community Based Services (HCBS) Plans of Care contain a Back-up Plan signed by the Member and/or authorized representative.

PM #16: Member training on identifying/reporting Critical Incidents.

- Group C, Group D, and Group E: UHCCP should ensure that the Care Manager educates the Member on identifying/reporting Critical Incidents.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2023 Annual Assessment Review of Care Management
UnitedHealthcare Community Plan

Review Period - July 1, 2022 to June 30, 2023
December 2023

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standards under review; interviews with key UHCCP staff (held via Teams meeting on November 28, 2023) and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on July 25, 2023, and received from the MCOs on August 7, 2023. The documentation review occurred offsite at IPRO beginning on August 8, 2023. The IPRO review team consisted of Carla Zuccarello, Rachel Fahey, and Lois Heffernan. The Care Management assessment covered the period from July 1, 2022 to June 30, 2023. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2023 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. UHCCP received an overall compliance score of 100% in 2023. In 2022, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X		-	-		-
CM32	X	X	-	-	-	-	-
CM34	X	X		-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X		-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

UnitedHealthcare Community Plan

November 2023

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1st through June 30th. Due to COVID-19 pandemic, the prior review period was from January 1, 2021 through August 14, 2021, during which time face to face visits were suspended and access to Nursing facilities was restricted. The review period for this audit was August 15, 2021 through August 31, 2022, during which time DMAHS issued the MCO Care Management Visit Guidance. Effective November 16, 2021, MCO Care Managers were to expand face to face visits to all MLTSS Members and resume completion of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities, allowing telephonic visits for Members who refused an in person visit, and for Nursing Facilities with visitation protocols restricting Care Manager access. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the *MCO Contracts* in *Article 9* from the *State of New Jersey DHS, DMAHS MCO Contract* to provide services dated July 2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022 to coincide with the State's *extension deadline for return to field activities*, disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to a NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

Capitation Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for UnitedHealthcare Community Plan (UHCCP), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on August 31, 2022.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on August 31, 2022.
- The Member cannot have been enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (August 31, 2022).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from August 15, 2021 to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from August 15, 2021 to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files, and uploading the files to IPRO's File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a 4-week period. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for UHCCP, 102 Member files were reviewed and included in the results pertaining to the Plan of Care for institutional settings. Two (2) cases were excluded as they did not meet eligibility criteria. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" were not included in scoring. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Tables 4–7**). A total of 100 files were reviewed for requirements regarding Facility and MCO Plan of Care (**Table 4**), MLTSS Initial Plan of Care and Ongoing Plans of Care (**Table 5**), Transition Planning (**Table 6**), and Reassessment of the Plan of Care and Critical Incident Reporting (**Table 7**). Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–7**).

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	65	100	65.0%
Documented review of the Facility Plan of Care by the care manager.	65	65	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	61	65	93.8%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	1	12	8.3%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	96	100	96.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	96	100	96.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	96	100	96.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1-Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	96	100	96.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	96	100	96.0%
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	0	N/A

N/A: not applicable

Table 6: Transition Planning

Transition Planning	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	4	100	4.0%
Evidence of the **care manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	1	100	1.0%

Transition Planning	N	D	Rate
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	99	100	99.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	54	100	54.0%
Members requiring coordination of care had coordination of care by the care manager.	99	100	99.0%
Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission.	72	100	72.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	79	100	79.0%
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.	21	100	21.0%
Care Manager reviewed the Member's rights and responsibilities.	53	100	53.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	55	100	55.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	54	100	54.0%

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for UHCCP, 100 Member files were reviewed and included in the results. Rates were calculated for state-requirement–specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 8**).

Table 8: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Table 9** and **Table 10**). Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 1 file was reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4; **Table 9**). Rates were calculated to profile NF/SCNF Members that transitioned to HCBS.

Table 9: NF/SCNF Members Transitioned to HCBS

Transition to HCBS	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
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting 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
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: not applicable.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 1 file was reviewed for Members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4; **Table 10**). Rates were calculated to profile HCBS Members that transitioned to a NF/SCNF.

Table 10: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member had a person-centered transition plan on file.	0	0	N/A
Member participated in a therapeutic leave.	0	0	N/A
Care Manager completed a risk management agreement for the Member when indicated.	0	0	N/A
Member was admitted to NF/SCNF directly from an acute facility.	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: not applicable.

The expansion of the NF audit components included evaluating the NF/SCNF population on the MLTSS PMs. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings are presented in **Table 11**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #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), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations (**Table 11)**.

Table 11: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	1	12	8.3%
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[2]	53	100	53.0%
#9a. Member's Plan of Care is amended based on change of Member condition[3]	0	0	N/A
#11. Plans of Care developed using "person-centered principles"[4]	96	100	96.0%
#16. Member training on identifying/reporting critical incidents	54	100	54.0%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an Initial Plan of Care.
[2] 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 and the end of the study period.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] 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 Plan of Care.
N/A: not applicable.

Discussion

Limitations

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–7**):

- Documented Review of the Facility Plan of Care by the Care Manager (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (93.8%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (96.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (96.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (96.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (96.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (96.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (99.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (99.0%)

Opportunities for Improvement for Audit Elements

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an institutional setting (**Tables 4–7**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (65.0%)
- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (8.3%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (4.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (1.0%)
- Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic 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) (54.0%)
- Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission (72.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (79.0%)
- 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 (21.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (53.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (55.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (54.0%)

Recommendations for Audit Elements

UHCCP's MLTSS Care Managers should ensure that the Member's care management record contains a copy of the Facility Plan of Care during the review period, the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program, identify Members for transfer to HCBS and offer Members options including transfer to the community, participate in at least one Interdisciplinary Team meeting during the review period, and ensure telephonic or onsite visits are timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. Care Managers should explain and discuss any payment liability with Members relating to their NF/SCNF admission. Care Managers should ensure the NJCA is completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment. Care Managers should also ensure the Plan of Care is updated, reviewed, and signed by the Member and/or representative and a copy is provided to the Member and/or representative, review the Member's Rights and Responsibilities under the MLTSS program annually, educate the Member on how to file a grievance and/or an appeal annually, and train on identifying/reporting critical incidents to specifically include how to identify abuse, neglect, and exploitation.

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (**Table 11**):

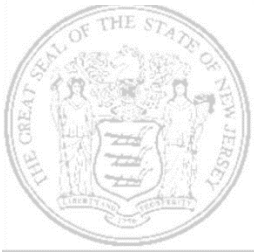
- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (8.3%)
- #9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary (53%)
- #16. Member training on identifying/reporting critical incidents (54.0%)

Recommendations for MLTSS Performance Measures

UHCCP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS and review Member's Plan of Care annually within 30 days of the Member's anniversary and as necessary. MLTSS Care Managers should provide Member training on identifying/reporting critical incidents.

As presented in **Table 9**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to HCBS. Since no files were reviewed in this category, specific conclusions and recommendations could not be determined. As presented in **Table 10**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix F: FC\WCHP 2023 Core Medicaid and MLTSS Care Management Audits



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Fidelis Care (Formerly WellCare Health Plans of New Jersey, Inc.)

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

November 2023

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MCO Care Management Chart Audit

Introduction

The purpose of the Care Management Audit was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

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

Methodology

The audit addressed MCO Contract requirements for Care Management services, including the NJ FamilyCare Managed Care Contract Articles 4.1.1, 4.2.6, 4.2.7, 4.3, 4.5, 4.6.2, 4.6.5, and 4.8.2, and the NJ Care Management Workbook. A representative sample of files for each population was selected for review. The audit included three phases: pre-audit activities, audit activities, and post-audit activities.

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, Contract references, NJ Care Management Workbook, and CDC Immunization Schedules. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations and applying the sampling methodology described below. The sampling methodology, as shown in Table 1, resulted in the selection of 159 cases for Fidelis Care, including a 10% oversample for the General Population.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range

within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 110 Enrollees for the General Population (including a 10% oversample required for substitutions or exclusions) was selected. All Enrollees were selected for the DDD Population as the total eligible population was less than 100 Enrollees (22). All Enrollees were selected for the DCP&P Population as the total eligible population was less than 100 Enrollees (27).

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Codes	Using the criteria below, a listing of eligible Enrollees is provided by DMAHS (DDD and DCP&P Enrollees, and TPL excluded). For each MCO, IPRO randomly selects 110 Enrollees for audit from this listing.	Capitation Codes 17399, 37399, 87399, 57599 and 59199. Using the above codes and the criteria below, IPRO selects a random sample of 110 Enrollees per MCO (TPL excluded) for audit.	Capitation Codes 49499 or 81299 OR PSC 600 and County Code less than 22. AND (Excluding MLTSS CAP Codes 79399, 78199, 78399, 78499, 89399, 88199, 88399, and 88499). Using the above codes and the criteria below, IPRO selects a random sample of 140 Enrollees per MCO (TPL excluded) for audit.
Age	>=3 months as of 12/31/2022	>= 3 months as of 12/31/2022	>= 3 months and < 18 years as of 12/31/2022
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2022 and 7/1/2022	Initial enrollment between 1/1/2022 and 12/31/2022	Initial enrollment between 1/1/2022 and 12/31/2022
• Existing Enrollees	Enrolled prior to 1/1/2022		
Current Enrollment	Enrolled as of 12/31/2022	No anchor date	No anchor date
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2022 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2022 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2022 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's FTP site.
- A file submission checklist to assist the MCO in preparing and submitting all information needed for the audit.

Audit Activities

IPRO reviewers conducted the file reviews over a four-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care 2023 CM Audit results for the review period 1/1/2022 to 12/31/2022 ranged from 46% to 95% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=22)	DCP&P (n=7)
Identification[1]	78%		
Outreach	86%	71%	75%
Preventive Services	67%	46%	58%
Continuity of Care	90%	87%	94%
Coordination of Services	95%	77%	92%

[1] The Identification category is not evaluated for the DDD and DCP&P Populations

GP Population Findings

A total of 100 files were reviewed for the GP Population. Of the 100 files reviewed, 15 Enrollees were New Enrollees, and 85 Enrollees were enrolled prior to the review period.

Identification

Table 3: Identification – GP Population

Identification	GP Population		
	Numerator	Denominator	Rate
Enrollee has an IHS on file completed during the audit period (1/1/22 to 12/31/22) (applies to New Enrollees only)*	5	15	33.3%
IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only)	4	5	80.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS)*	6	10	60.0%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only)	0	4	0.0%
Enrollees identified by the Plan as having potential Care Management needs (applies to New Enrollees only where IHS score is less than 5 or no IHS on file)*	7	13[1]	53.8%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to New Enrollees only)	1	6	83.3%[2]
Enrollees enrolled in MCO's Care Management Program (applies to existing Enrollees enrolled prior to 11/16/2021 or existing Enrollees newly enrolled in CM during the review period)*	31	85	36.5%
Enrollees identified by IPRO as having potential CM needs during the review period that the MCO did not identify (applies to Existing Enrollees enrolled prior to 11/16/2021)	9	54	83.3%[2]
Enrollees identified by the Plan as having potential Care Management needs (applies to Existing Enrollees not enrolled in Care Management prior to 11/16/2021 or during the review period).*	32	45	71.1%

**Not Included in aggregate score calculation*

[1]Denominator includes 10 (ten) cases with no IHS on file and 3 (three) cases with an IHS score less than 5

[2] Percentage rate is indicative of an inverse percentage – higher score is indicative of positive performance

Outreach

This section applies only to Existing Enrollees not in Care Management prior to 11/16/21 where the MCO identified need, and to New Enrollees where the MCO identified need based on an IHS score greater than or equal to 5, or through other means where no IHS was on file or the IHS score was less than 5.

Table 4: Outreach – GP Population

Outreach	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	51	100	51.0%
The MCO completed a CNA during the audit period*	8	51	15.7%
For Enrollees with no CNA on file, initial outreach to complete a CNA was done	37	43	86.0%
For Enrollees with no CNA on file, the outreach for CNA was timely within 30 days of the identification of CM needs	32	37	86.5%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	23	37	62.2%
Aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	30	37	81.1%
When the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	28	30	93.3%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	19	23	82.6%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	19	23	82.6%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees in Care Management during the review period. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. Fidelis Care had a total of 33 cases in the General Population who were in Care Management during the review period.

Table 5: Preventive Services – GP Population

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	1	2	50.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	1	1	100.0%

Preventive Services	GP Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	0	2	0.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	1	2	50.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	14	31	45.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	11	17	64.7%
Dental needs are addressed for Enrollees (aged 21 and above)	29	31	93.5%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	0	2	0.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	2	2	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	2	2	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	1	0.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	1	1	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	1	1	100.0%

**Not Included in aggregate score calculation*

Continuity of Care

This section includes Enrollees in Care Management during the review period (33). Twenty-one (21) cases were in Care Management prior to 11/16/21. Twelve (12) cases (2 New Enrollees and 10 Existing Enrollees) were new to Care Management during the review period. Community Based Care Management is reported based on files received from the MCO.

Table 6: Continuity of Care – GP Population

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
All Enrollees who met criteria for the CNA*	51	100	51.0%
The MCO completed a CNA during the audit period*	8	51	15.7%
For the Enrollees that completed a CNA during the audit period, the completed CNA contained all elements of the State approved CNA tool	8	8	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days following an IHS score of 5 or greater). Timeliness can only be determined for Enrollees with an IHS on file	0	0	NA[1]
A level of Care Management was determined for the Enrollee	8	8	100.0%
The Enrollee is in Community Based Care Management (CBCM). Does not include Enrollees who declined Care Management*	0	33	0.0%

Continuity of Care	GP Population		
	Numerator	Denominator	Rate
A Care Plan was completed for the Enrollee that included all required components	25	33	75.8%
The Care Plan was developed within 30 days of CNA completion	8	8	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances or, for Existing Enrollees with no identified change in needs, Care Plan was monitored.	24	24	100.0%
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan progressed in a timely manner without unreasonable interruption	1	1	100.0%

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Coordination of Services

This section includes Enrollees in Care Management during the review period (33). Twenty-one (21) cases were in Care Management prior to 11/16/21. Twelve (12) cases (2 New Enrollees and 10 Existing Enrollees) were new to Care Management during the review period.

Table 7: Coordination of Services – GP Population

Coordination of Services	GP Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	32	33	97.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	20	20	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	12	13	92.3%
For Enrollees who were hospitalized, adequate discharge planning was performed	18	20	90.0%

DDD Population Findings

A total of 22 files were reviewed for the DDD Population.

Outreach

Table 8: Outreach – DDD Population

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	10	22	45.5%
Initial outreach to complete a CNA was done	17	22	77.3%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	7	12	58.3%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	1	7	14.3%
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	7	7	100.0%
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	7	7	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	1	1	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management*	1	1	100.0%

**Not Included in aggregate score calculation*

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DDD Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. Fidelis Care had a total of 22 cases in the DDD Population.

Table 9: Preventive Services – DDD Population

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	2	5	40.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	3	3	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	3	3	100.0%

Preventive Services	DDD Population		
	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	0	4	0.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	3	4	75.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	3	18	16.7%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	4	15	26.7%
Dental needs are addressed for Enrollees (aged 21 and above)	9	17	52.9%
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	2	5	40.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	3	3	100.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	3	3	100.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	2	0.0%
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	2	2	100.0%
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	2	2	100.0%

**Not Included in aggregate score calculation*

Continuity of Care

This section applies to all DDD members (22).

Table 10: Continuity of Care – DDD Population

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	10	22	45.5%
The completed CNA contained all elements of the State approved CNA tool	10	10	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	10	10	100.0%
A level of Care Management was determined for the Enrollee	8	10	80.0%
The Enrollee is in Community Based Care Management (CBCM)*	0	22	0.0%
A Care Plan was completed for the Enrollee that included all required components	17	22	77.3%
The Care Plan was developed within 30 days of CNA Completion	10	10	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	NA[2]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs and the treatment plan	0	1	0.0%

Continuity of Care	DDD Population		
	Numerator	Denominator	Rate
progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*
[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA
[2]NA: Not Applicable

Coordination of Services

This section applies to all DDD Members (22).

Table 11: Coordination of Services – DDD Population

Coordination of Services	DDD Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists and the local health department (LHD)	17	22	77.3%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	0	0	NA[1]
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	0	0	NA[1]
For Enrollees who were hospitalized, adequate discharge planning was performed	0	0	NA[1]
For Enrollees who were hospitalized with a MH/BH diagnosis and discharged prior to 12/1/2022 the Care Manager documented evidence of follow up within 30 days of discharge	0	0	NA[1]
The Care Manager made aggressive attempts to determine follow up status with a MH/BH provider for Enrollees hospitalized with a MH/BH diagnosis	0	0	NA[1]

[1]NA: Not Applicable

DCP&P Population Findings

A total of 27 files were reviewed for the DCP&P Population. 20 files were excluded from the DCP&P Population and were not subject to further review in the following categories. Fidelis Care had a total of 7 cases in the DCP&P Population.

Outreach

Table 12: Outreach – DCP&P Population

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	6	7	85.7%
Initial outreach to complete a CNA was done	6	7	85.7%
For Enrollees with no CNA on file, the outreach for CNA was timely within 45 days of enrollment	0	1	0.0%
For Enrollees with no CNA on file, outreach was successful (even if the Enrollee declines to complete the CNA)*	0	0	NA[1]
For Enrollees with no CNA on file, aggressive outreach to complete a CNA was needed because initial outreach was unsuccessful*	0	0	NA[1]
For Enrollees with no CNA on file, when the initial outreach was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA*	0	0	NA[1]
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.	0	0	NA[1]

**Not Included in aggregate score calculation*

[1]NA: Not Applicable

Preventive Services

This section includes all Enrollees regardless of Care Management status. For the DCP&P Population, MCOs are required to conduct passive Care Management for Members declining Care Management. Age limit restrictions apply to specific questions. These restrictions are noted in the table below. Fidelis Care had a total of 7 cases in the DCP&P Population.

Table 13: Preventive Services – DCP&P Population

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20)	6	7	85.7%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	1	0.0%

Preventive Services	DCP&P Population		
	Numerator	Denominator	Rate
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20)	0	1	0.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source	3	7	42.9%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18)	3	4	75.0%
Appropriate vaccines have been administered for Enrollees (aged 19 and above)	0	0	NA[1]
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above)	0	0	NA[1]
Dental needs are addressed for Enrollees (aged 21 and above)			
A dental visit occurred during the review period for Enrollees (aged 1 through 20)	1	5	20.0%
Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20)	3	4	75.0%
Dental reminders were sent to Enrollees (aged 1 through 20)	3	4	75.0%
For Enrollees (aged 9 months to 72 months) the Enrollee file contained lead history*	0	0	NA[1]
Care Manager made attempts to obtain lead status for Enrollees (aged 9 months to 72 months)	0	0	NA[1]
Care Manager sent lead screening reminders for Enrollees (aged 9 months to 72 months)	0	0	NA[1]

**Not Included in aggregate score calculation*
[1]NA: Not Applicable

Continuity of Care

This section applies to all DCP&P Members (7).

Table 14: Continuity of Care – DCP&P Population

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a CNA during the audit period*	6	7	85.7%
The completed CNA contained all elements of the State approved CNA tool	6	6	100.0%
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment)[1]	5	6	83.3%
A level of Care Management was determined for the Enrollee	6	6	100.0%
A Care Plan was completed for the Enrollee that included all required components	6	7	85.7%
The Care Plan was developed within 30 days of CNA Completion	6	6	100.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances	0	0	NA[2]
For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to	0	0	NA[2]

Continuity of Care	DCP&P Population		
	Numerator	Denominator	Rate
address the Enrollee's specific needs, and the treatment plan progressed in a timely manner without unreasonable interruption			

**Not Included in aggregate score calculation*

[1]The measure is calculated using initial MCO eligibility date with the date of completed CNA

[2]NA: Not Applicable

Coordination of Services

This section applies to all DCP&P Members (7).

Table 15: Coordination of Services – DCP&P Population

Coordination of Services	DCP&P Population		
	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)	6	7	85.7%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services	5	5	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee	0	0	NA[1]
For Enrollees who were hospitalized, adequate discharge planning was performed	1	1	100.0%

[1]NA:Not Applicable

Limitations

Audit results for the DDD and DCP&P Populations should be considered cautiously due to the low sample size of 22 and 7 respectively.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (86%)
- Continuity of Care (General Population) (90%)
- Coordination of Services (General Population) (95%)

- Continuity of Care (DDD Population) (87%)

- Continuity of Care (DCP&P Population) (94%)
- Coordination of Services (DCP&P Population) (92%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (78%)
- Preventive Services (General Population) (67%)

- Outreach (DDD Population) (71%)
- Preventive Services (DDD Population) (46%)
- Coordination of Services (DDD Population) (77%)

- Outreach (DCP&P Population) (75%)
- Preventive Services (DCP&P Population) (58%)

Care Management Annual Assessment

Care Management

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Fidelis Care, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key Fidelis Care staff via WebEx held on May 9, 2023; and post audit evaluation of documentation and audit activities.

To assist in submission of appropriate documentation, IPRO developed the Core Medicaid Care Management Document Submission Guide. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The documentation for the audit review was requested by IPRO on February 10, 2023, and documentation was received from the MCOs on February 27, 2023. The documentation review occurred offsite at IPRO beginning on February 28, 2023. The audit review team was made up of Carla Zuccarello, Juana Torres, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2022 to December 31, 2022.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all of the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. Fidelis Care received an overall compliance score of 73% in 2023. In 2022, the MCO received a score of 80%. Review of the elements CM2, CM3, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2023. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2022 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).**Table 17** presents an overview of the results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	X	-	-	-	X	-
CM3	-	-	X	-	X	-	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	X	-	X	-	-	-	X
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	-	X	-	-	-	X
CM16	X	X	-	-	-	-	-
CM17	X	-	X	-	-	-	X
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM19	-	-	X	-	X	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**24**	**22**	**8**	**0**	**5**	**1**	**3**
Compliance Percentage		**73%**					

[1]This documentation element is reviewed annually as all elements are subject to review.

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 83.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees only). 83.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 80.0% - IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only). 0.0% - When the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only).

Element	Contract Language	Reviewer Comments
	Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO's assessment tool.	**In the 2023 CM file audit, the MCO scored for the DDD Enrollees:** 77.3% - Initial outreach to complete a CNA was done. 58.3% - The outreach to complete a CNA was done timely within 45 days of the Enrollee's enrollment. 80.0% - A level of Care Management was determined for the Enrollee. **In the 2023 CM file audit, the MCO scored for the DCP&P Enrollees:** 0.0% - The outreach to complete a CNA was done timely within 45 days of the Enrollee's enrollment. 83.3% - The Comprehensive Needs Assessment was completed timely within 45 days of Enrollee's enrollment.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 75.8% - A Care Plan was completed for the Enrollee that included all required components. **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 77.3% - A Care Plan was completed for the Enrollee that included all required components.

Element	Contract Language	Reviewer Comments
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2023 CM file audit the MCO scored for the General Population Enrollees:** 50.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 0.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 50.0% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 0 through 18). 45.2% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 64.7% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 0.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 40.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 0.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 75.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).

Element	Contract Language	Reviewer Comments
		16.7% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 26.7% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 52.9% - Dental needs are addressed for Enrollees (aged 21 and above). 40.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). **In the 2023 CM file audit the MCO scored for the DCP&P Enrollees:** 0.0% - Aggressive outreach attempts were documented to confirm EPSDT status (aged 0 through 20). 0.0% - The Care Manager sent EPSDT reminders (aged 0 through 20). 42.9% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 75.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 20.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). 75.0% - Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20). 75.0% - Dental reminders were sent to Enrollees (aged 1 through 20).

Element	Contract Language	Reviewer Comments
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 0.0% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs.
CM17	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**In the 2023 CM file audit the MCO scored for the DDD Enrollees:** 0.0% - For Enrollees with a treatment plan, the treatment plan progressed timely.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2023 CM file audit the MCO scored for the DDD Population Enrollees:** 77.3% - When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH), and DCP&P; the family, PCPs, specialists, and the local health department (LHD).

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.

Recommendations

For the General Population:

1. **CM3:** Fidelis Care should ensure that New and Existing Enrollees with potential CM needs are appropriately identified.
2. **CM6**: Fidelis Care should ensure that for New Enrollees, an IHS is completed within 45 days of enrollment, and aggressive outreach is attempted and documented when initial outreach is unsuccessful, within 45 days of the Enrollee's enrollment.
3. **CM8:** Fidelis Care should ensure the Care Plan is completed for the Enrollee and includes all required components.
4. **CM14:** Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source.
5. **CM14:** Fidelis Care should ensure immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status.
6. **CM14:** Fidelis Care should ensure for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status.
7. **CM14:** For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period.

For the DDD Population:

1. **CM7:** Fidelis Care should ensure that initial outreach to complete CNA is timely, within 45 days of Enrollee's enrollment.
2. **CM7:** Fidelis Care should ensure a level of Care Management is determined for the Enrollee.
3. **CM8:** Fidelis Care should ensure a Care Plan is completed for the Enrollee and includes all required components.
4. **CM14:** Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source.
5. **CM14:** Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status.
6. **CM14:** Fidelis Care should ensure that for Enrollees (aged 19 and above), appropriate vaccines have been administered, and aggressive outreach attempts are documented to confirm immunization status.
7. **CM14:** Fidelis Care should ensure that for Enrollees (aged 21 and above), dental needs are addressed.
8. **CM14**: Fidelis Care should ensure that a dental visit occurs for Enrollees (aged 1 through 20) during the review period.
9. **CM15:** Fidelis Care should ensure for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.
10. **CM17:** For Enrollees who are given a treatment plan**,** Fidelis Care should ensure that the treatment plan progresses in a timely manner without unreasonable interruption.

11. **CM19:** When appropriate for the applicable Enrollees, Fidelis Care should ensure that the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD), and that documentation of all contacts and linkages, to medical and other services, in are in the Enrollee's case files.

For the DCP&P Population:

1. **CM7:** Fidelis Care should ensure that the outreach to complete a CNA and the completion of the CNA occurs timely, within 45 days of Enrollee's enrollment.
2. **CM14:** Fidelis Care should ensure that aggressive outreach attempts are documented to confirm EPSDT status and EPSDT reminders are sent for Enrollees (aged 0 through 20).
3. **CM14:** Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status.
4. **CM14:** For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period, the Care Manager makes attempts to obtain dental status, and dental reminders are sent.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Fidelis Care (formerly WellCare Healthplans of NJ, Inc.)

Review Period July 1, 2022 – June 30, 2023

February 2024

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Effective November 16, 2021, following State guidance, Managed Care Organizations expanded face-to-face visits to all MLTSS Members and resumption of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. In addition, the NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting* was in effect during this review period. The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2022 to June 30, 2023.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated August 2022 and February 2023. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, and contract references.

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

Cap Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

The sampling methodology as shown in **Table 2** resulted in the selection of 135 cases for Fidelis Care including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2022 and 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2022 and 1/1/2023. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2023 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2022 and continuously enrolled in MLTSS through 6/30/2023	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2022. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2023 in the *same* MCO with no gaps in enrollment.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 75 MLTSS HCBS Members across subgroups C and D, and 25 MLTSS HCBS 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 MLTSS HCBS 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, as well as ensure an adequate denominator to evaluate Performance Measures. In addition, there was an ancillary group of at least 25 MLTSS HCBS Members randomly selected from subgroups C and D that were used to collect information related to MLTSS Performance Measure #8 (Plans of Care established within 45 days of MLTSS enrollment).

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

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

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the total 135 cases selected for the Fidelis Care, 125 Member files were reviewed and 121 were included in the results:

Description	Group C	Group D	Group E	Ancillary Group	Subtotal
Total Number of Files Reviewed	10	65	25	25	125
Exclusions	1	2	0	1	4
Number of Files included in Results	9	63	25	24	121

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits *or* Telephonic Monitoring, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care's audit results for the combined MLTSS sample ranged from 90.3% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

	July 1, 2022 to June 30, 2023			
Determination by Category	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	91.2%	92.0%	92.0%
Member Outreach	77.8%	92.1%	--	90.3%
Face-to-Face Visits *or* Telephonic Monitoring	97.1%	99.3%	97.8%	98.7%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	96.1%	97.3%	95.2%	96.7%
Ongoing Care Management	100.0%	92.8%	85.3%	92.1%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

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

[2]Member outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

[3]Calculated as an aggregate score by combining elements applicable to each category

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 10 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). 1 file was excluded. All 9 files were further reviewed for compliance in 6 categories. There were 2 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJCA for the Member from OCCO.*	3	9	33.3%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	3	3	100.0%
OCCO response was received within 5 business days of the MCO request.*	0	3	0.0%
The MCO received a NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	3	0.0%
OCCO completed the NJ Choice Assessment which is valid during the review period.*	2	9	22.2%
The MCO completed the NJ Choice Assessment with the Member.	7	7	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	7	9	77.8%

Telephonic Monitoring or Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	9	9	100.0%
Member is unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.[1]	7	7	100.0%
Member was offered the participant direction option.[2]	7	7	100.0%
Member chose to participate in participant direction. (excludes Members residing in CARS).*	5	7	71.4%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[2]	5	5	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).[1]	7	7	100.0%

A cost effective analysis was completed during the review period.	8	9	88.9%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	8	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment
[2]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	8	9	88.9%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	9	9	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	0	7	0.0%
Member was assessed for PCA services (excludes Members residing in CARS)*	7	7	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	5	7	71.4%
Member required another PCA assessment due to changes in condition (excludes Members in CARS)*	0	7	0.0%
Member was re-assessed for PCA due to changes in condition.[1]	0	0	N/A
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	9	9	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	9	9	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	9	9	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	9	9	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	7	7	100.0%

Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	7	7	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	7	7	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	7	7	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the back-up Plan reviewed with the Member at least on a quarterly basis.[1]	7	7	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	7	7	100.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	8	9	88.9%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	9	9	100.0%
Member's residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	7	7	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	1	7	14.3%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	0	1	0.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	7	7	100.0%
Member experienced issues that impeded access to care.*	0	9	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate CM follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	9	9	100.0%
Member required a change in Plan of Care based on an increase or reduction of services. *	0	9	0.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	0	0	N/A

Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	9	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	0	0	N/A
Member was discharged to his/her own home and in home services were in place in a timely manner.	0	0	N/A
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	7	7	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS)*	0	7	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the care manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	9	9	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 65 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). 2 files were excluded. All 63 files were further reviewed for compliance in all 6 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an SCS tool completed.*	56	63	88.9%
Member enrolled into MLTSS on an SCS Waiver.*	51	56	91.1%
NJCA completed within 30 days of a referral to MLTSS.	0	5	0.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	62	63	98.4%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	58	63	92.1%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	63	63	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	62	62	100.0%
Member had PPP services prior to MLTSS enrollment (excludes Members in CARS).*	1	63	1.6%
Member was offered the participant direction option.[1]	62	62	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	18	62	29.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	18	18	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	62	62	100.0%

A cost effective analysis was completed during the review period.	61	63	96.8%
The Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	61	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed, signed/verbally acknowledged Initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	61	63	96.8%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	63	63	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	7	63	11.1%
Member was assessed for PCA services (excludes Members residing in CARS).*	22	56	39.3%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	18	22	81.8%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	6	22	27.3%
Member was re-assessed for PCA due to changes in condition.[1]	6	6	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	62	62	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	63	63	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	63	63	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	63	63	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	63	63	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	63	63	100.0%

Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	63	63	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	63	63	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	58	63	92.1%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	61	63	96.8%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	60	63	95.2%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	63	63	100.0%
Member's residing in their community home had a Risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	61	63	96.8%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	8	61	13.1%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	0	8	0.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation). [1]	62	63	98.4%
Member experienced issues that impeded access to care.*	1	63	1.6%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	1	1	100.0%
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	57	63	90.5%
Member required a change in Plan of Care based on an increase or reduction of services.*	12	63	19.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	11	12	91.7%
Member file indicates disagreement with the Plan of Care.*	0	1	0.0%

Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	63	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	0	2	0.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	1	2	50.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	10	10	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	63	63	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	2	63	3.2%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	63	63	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 25 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). No files were excluded. The Member Outreach category is not assessed for Group E, as these Members are not new to MLTSS. All 25 files were reviewed for compliance in 5 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	23	25	92.0%
The MCO completed the NJ Choice Assessment at a face-to-face visit.	23	25	92.0%

Face-to-Face Visits or Telephonic Monitoring	N	D	Rate
Member participated in all face-to-face visits.*	25	25	100.0%
Member was unable to participate in onsite/telephonic meeting due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit/telephonic meeting with the Care Manager.*	0	0	N/A
Member or authorized representative refused to participate in any face-to-face visits.*	0	0	N/A
Member or authorized representative refused to participate in the NJ Choice Assessment in-person visit.*	0	0	N/A
Options Counseling was provided to the Member.	23	23	100.0%
Member had PPP services prior to review period (excludes Members residing in CARS).*	7	25	28.0%
Member was offered the participant direction option.[1]	18	18	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	1	18	5.6%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had a completed and signed Interim Plan of Care (IPOC).	23	23	100.0%
A cost effective analysis was completed during the review period.	23	25	92.0%
The Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	23	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
N/A: Not Applicable

Ongoing Plan of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	23	23	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	25	25	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	24	25	96.0%
Member required another PCA assessment due to changes in condition. (excludes Members residing in CARS)*	3	25	12.0%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	23	23	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	25	25	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	25	25	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	25	25	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	25	25	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	25	25	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	19	25	76.0%
Member service preference levels were documented in the Back-up Plan.[1]	25	25	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	20	25	80.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	23	25	92.0%
Member file included a Member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	23	25	92.0%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	25	25	100.0%

Care Manager completed an Annual Risk Assessment for the Member.[1]	22	25	88.0%
Members who were identified as having a positive risk.*	0	22	0.0%
Members who were identified as having a positive risk, had a signed/verbally acknowledged Risk Management Agreement with all components.[1]	0	0	N/A
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.[2]	1	22	95.5%[2]

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member experienced issues that impeded access to care.*	0	25	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	20	25	80.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	4	25	16.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care.	4	4	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
The Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	25	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge.	1	1	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	1	1	100.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed/verbally acknowledged by the Member and/or authorized representative.	3	3	100.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in a community alternative residential setting (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	25	100.0%
Member reported a gap in service delivery (excludes Members in CARS)*	0	25	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	25	25	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment, #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change in Member condition), #10 (Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan, and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2022-2023 audit findings. Overall, Fidelis Care's audit results ranged from 92.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	8	9	88.9%
	Group D	61	63	96.8%
	Group E[4]			
	Ancillary C	3	3	100.0%
	Ancillary D	19	21	90.5%
	Total	91	96	94.8%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	23	25	92.0%
	Total	23	25	92.0%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	Group C	0	0	N/A
	Group D	10	10	100.0%
	Group E	3	3	100.0%
	Total	13	13	100.0%
#10. Plans of Care for MLTSS Members are aligned with Members needs identified during the NJ Choice Assessment.	Group C	9	9	100.0%
	Group D	62	62	100.0%
	Group E	23	23	100.0%
	Total	94	94	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	9	9	100.0%
	Group D	63	63	100.0%
	Group E	25	25	100.0%
	Total	97	97	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a Back-up Plan.[3]	Group C	7	7	100.0%
	Group D	63	63	100.0%
	Group E	25	25	100.0%
	Total	95	95	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	9	9	100.0%
	Group D	63	63	100.0%
	Group E	25	25	100.0%
	Total	97	97	100.0%

[1]Group C: Members New to Managed Care and Newly Eligible to MLTSS; Group D: Current Members Newly Enrolled to MLTSS; Group E: Members Enrolled in the MCO and MLTSS prior to the review period
[2]Members who did not have a documented change in condition during the study period are excluded from this measure
[3]Members residing in a community alternative residential setting (CARS) are excluded from this measure
[4]Group E Members are excluded from this measure as they are not new to MLTSS
[5]Members who have not been enrolled in MLTSS for at least one year are excluded from this measure
N/A: Not Applicable

Discussion

Limitations

COVID-19 flexibilities were in place related to specific Care Management activities to allow Care Managers to conduct telephonic monitoring if the Member refused an in-person visit, including the NJ Choice Assessment face-to-face visit, with evidence of documented refusals in the Member file. The MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5). Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could only be evaluated for those Members not enrolled through the SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below. Opportunities for Improvement for elements at the group level with a score below 86% are provided for the following categories: Member Outreach and Ongoing Care Management.

Assessment

Across all three groups, the MCO had a combined score of 92.0% in the Assessment category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	91.2%
Group E	92.0%
Combined	92.0%

Member Outreach

Across groups, the MCO had a combined score of 90.3% in the Member Outreach category.

Group	7/1/22 to 6/30/23
Group C	77.8%
Group D	92.1%
Group E[1]	
Combined	90.3%

[1]Initial outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level *with a score less than 86%* in the *Member Outreach* category include the following:

- Group C: Fidelis Care should ensure that initial outreach to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) is completed within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits or Telephonic Monitoring

Across all three groups, the MCO had a combined score of 98.7% in the Face-to-Face Visits or Telephonic Monitoring category.

Group	7/1/22 to 6/30/23
Group C	97.1%
Group D	99.3%
Group E	97.8%
Combined	98.7%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 96.7% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/22 to 6/30/23
Group C	96.1%
Group D	97.3%
Group E	95.2%
Combined	96.7%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 92.1% in the Ongoing Care Management category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	92.8%
Group E	85.3%
Combined	92.1%

Opportunities for Improvement for elements at the group level *with a score less than 86%* in the *Ongoing Care Management* category include the following:

- Group E: Fidelis Care should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/22 to 6/30/23
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, Fidelis Care scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2023 Annual Assessment Review of Care Management
Fidelis Care (formerly WellCare Health Plans of New Jersey, Inc.)

Review Period - July 1, 2022 to June 30, 2023
December 2023

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That the services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

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

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Fidelis Care, as evidence of compliance of the standards under review; interviews with key Fidelis Care staff (held via Teams meeting on November 28, 2023) and post-offsite evaluation of documentation and offsite activities.

To assist in submission of appropriate documentation, IPRO developed the New Jersey Annual Assessment of MCO Operations Document Submission Guide. This document closely follows the NJ Family Care Managed Care Contract and was developed to assess MCO compliance.

The offsite review of documentation was requested by IPRO on July 25, 2023, and received from the MCOs on August 7, 2023. The documentation review occurred offsite at IPRO beginning on August 8, 2023. The IPRO review team consisted of Carla Zuccarello, Cynthia Santangelo, Rachel Fahey, and Lois Heffernan. The Care Management assessment covered the period from July 1, 2022 to June 30, 2023. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all the required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2023 MLTSS Care Management review. Full results of the MLTSS Care Management Compliance Audit are in progress and final reports will be sent upon completion.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the plan. Findings for Improvement relate to suggestions by the review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. Fidelis Care received an overall compliance score of 100% in 2023. In 2022, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Fidelis Care (formerly WellCare Health Plans of New Jersey, Inc.)

November 2023

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ISO 9001:2015 CERTIFIED

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period. Typically, the review period for the annual Nursing Facility audit is from July 1st through June 30th. Due to COVID-19 pandemic, the prior review period was from January 1, 2021 through August 14, 2021, during which time face to face visits were suspended and access to Nursing facilities was restricted. The review period for this audit was August 15, 2021 through August 31, 2022, during which time DMAHS issued the MCO Care Management Visit Guidance. Effective November 16, 2021, MCO Care Managers were to expand face to face visits to all MLTSS Members and resume completion of the NJ Choice Assessment. COVID-19 flexibilities were in place related to specific Care Management activities, allowing telephonic visits for Members who refused an in person visit, and for Nursing Facilities with visitation protocols restricting Care Manager access. In addition to the CM audit, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed the MCO contract requirements for monitoring performance based on the *MCO Contracts* in *Article 9* from the *State of New Jersey DHS, DMAHS MCO Contract* to provide services dated July 2021 through January 2022. A representative sample of files was selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, and contract references. IPRO and DMAHS agreed to extend the review period to August 31, 2022 to coincide with the State's *extension deadline for return to field activities*, disseminated to the MCOs on March 28, 2022. In 2020, IPRO and DMAHS collaborated on revising the *NJ EQRO MLTSS NF/SCNF Care Management Audit Tool* to improve and refine the audit process by eliminating "not applicable" (N/A) conditions in the individual audit questions. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2020, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to a Plan of Care for institutional settings, NF/SCNF Members transferred to HCBS and HCBS Members transferred to a NF/SCNF. MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population.

Rates calculated from this audit tool section would be utilized to determine MCO performance. Separate rates would be calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and a NF/SCNF setting during the review period. These rates would be utilized solely for informational purposes.

Population Selection

Capitation and plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

Capitation Code	Description
89399	MLTSS Eligible Without Medicare - HCBS
79399	MLTSS Eligible With Medicare - HCBS

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

One MLTSS NF/SCNF population was selected for each MCO. A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Fidelis Care, inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on August 31, 2022.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on August 31, 2022.
- The Member cannot have been enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (August 31, 2022).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from August 15, 2021 to June 30, 2022, with the MCO of record on August 31, 2022.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from August 15, 2021 to August 31, 2022, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and was still residing in the NF/SCNF as of August 31, 2022).
Group 4	Members residing in HCBS for at least 1 month between August 15, 2021 to August 31, 2022, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files, and uploading the files to IPRO's File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's FTP site. IPRO reviewers conducted the offsite file reviews over a 4-week period. Reviewer inter-rater reliability (IRR) was maintained through use of the standardized audit tool, and ongoing communication and coordination among the review team.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the cases selected for Fidelis Care, 100 Member files were reviewed and included in the results pertaining to the Plan of Care for institutional settings. Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Requirements scored as "N/A" were not included in scoring. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Tables 4–7**). A total of 100 files were reviewed for requirements regarding the Facility and MCO Plan of Care (**Table 4**), MLTSS Initial Plan of Care and Ongoing Plans of Care (**Table 5**), Transition Planning (**Table 6**), and Reassessment of the Plan of Care and Critical Incident Reporting (**Table 7**). Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–7**).

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	90	100	90.0%
Documented review of the Facility Plan of Care by the Care Manager.	88	90	97.8%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	88	90	97.8%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	2	4	50.0%
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	99	100	99.0%
Care Manager arranged Plan of Care services using both formal and informal supports.	99	100	99.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	99	100	99.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1-Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	99	100	99.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	99	100	99.0%
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	2	50.0%

Table 6: Transition Planning

Transition Planning	N	D	Rate
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	4	100	4.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	42	100	42.0%
Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	100	100	100.0%
Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	66	100	66.0%
Members requiring coordination of care had coordination of care by the Care Manager.	100	100	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.	98	100	98.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.	96	100	96.0%
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.	89	100	89.0%
Care Manager reviewed the Member's rights and responsibilities.	100	100	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	100	100	100.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	100	100	100.0%

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for Fidelis Care, 100 Member files were reviewed and included in the results. Rates were calculated for state-requirement–specific questions pertaining to Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 8**).

Table 8: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period	100
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility as of the end of the review period	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period	0

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population (**Table 9** and **Table 10**). Abbreviated review elements appear in bold in the table sections of this report.

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting (Groups 2 and 4; **Table 9**). Rates were calculated to profile NF/SCNF Members that transitioned to HCBS.

Table 9: NF/SCNF Members Transitioned to HCBS

Transition to HCBS	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
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting 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
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: not applicable.

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for Members receiving HCBS and subsequently transitioned to a NF/SCNF for long-term placement (Groups 3 and 4; **Table 10**). Rates were calculated to profile HCBS Members that transitioned to a NF/SCNF.

Table 10: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member had a person-centered transition plan on file.	0	0	N/A
Member participated in a therapeutic leave.	0	0	N/A
Care Manager completed a risk management agreement for the Member when indicated.	0	0	N/A
Member was admitted to NF/SCNF directly from an acute facility.	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: not applicable.

The expansion of the NF audit components included evaluating the NF/SCNF population on the MLTSS PMs. There were no changes made to the applicable MLTSS PMs for the current review period. Population-specific findings are presented in **Table 11**, which present results on the following MLTSS Performance Measures: #8 (Initial Plan of Care established within 45 calendar days of enrollment into MLTSS), #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), #11 (Plans of Care developed using "person-centered principles"), and #16 (Member training on identifying/reporting critical incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations (**Table 11)**.

Table 11: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Initial Plan of Care established within 45 days of enrollment into MLTSS[1]	2	4	50.0%
#9. Member's Plan of Care is reviewed annually within 30 days of the Member's anniversary and as necessary[2]	100	100	100.0%
#9a. Member's Plan of Care is amended based on change of Member condition[3]	1	2	50.0%
#11. Plans of Care developed using "person-centered principles"[4]	99	100	99.0%
#16. Member training on identifying/reporting critical incidents	100	100	100%

[1] Compliance with Performance Measure (PM) #8 was calculated using 45 calendar days to establish an Initial Plan of Care.
[2] 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 and the end of the study period.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] 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 Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members during the review period in Group 2 (Members who transitioned from a NF/SCNF to HCBS), Group 3 (Members who transitioned from HCBS to the NF/SCNF), and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS).

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–7**):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (90.0%)
- Documented Review of the Facility Plan of Care by the Care Manager (97.8%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care (97.8%)
- Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services (99.0%)
- Care Manager arranged Plan of Care services using both formal and informal supports (99.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process (99.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this) (99.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record (99.0%)
- Member was present at each onsite/telephonic 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/telephonic visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable) (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager (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 (98.0%)
- NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment (96.0%)
- 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 (89.0%)
- Care Manager reviewed the Member's Rights and Responsibilities (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal (100.0%)
- Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (100.0%)

Opportunities for Improvement for Audit Elements

Opportunities for improvement for review elements scored below 86% exist in the following elements pertaining to the Plan of Care in an institutional setting (**Tables 4–7**):

- The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program (50.0%)
- 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 (50.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community (4.0%)
- Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period (42.0%)
- Onsite/Telephonic 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) (66.0%)

Recommendations for Audit Elements

Fidelis Care's MLTSS Care Managers should ensure the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within 45 calendar days of enrollment into the MLTSS program, ensure that the Plan of Care is updated for a significant change, identify Members for transfer to HCBS and offer Members options including transfer to the community, participate in at least one IDT meeting during the review period, and ensure telephonic or onsite visits are timely and occur within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members.

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for PMs that scored below 86% exist for the following PMs (**Table 11**):

- #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (50.0%)
- #9a. Member's Plan of Care is amended based on change of Member condition (50.0%)

Recommendations for MLTSS Performance Measures

Fidelis Care's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS program and amend the Member's Plan of Care based on change of the Member's condition.

As presented in **Table 9**, the MCO provided documentation to support compliance against the contractual requirements for Groups 2 and 4, Members transitioning from a NF/SCNF setting to HCBS. Since no files were reviewed in this category, specific conclusions and recommendations could not be determined. As presented in **Table 10**, the MCO provided documentation to support the following review elements pertaining to the HCBS Members transitioning to a NF/SCNF setting (Groups 3 and 4). Since no files were reviewed in this category, conclusions and recommendations could not be determined.

Appendix G: Supplemental Documents – Submission Guides for 2023 Annual Assessment Review and 2023 Care Management Audits (Core Medicaid and MLTSS)

New Jersey Annual Assessment of MCO Operations

2023 Core Medicaid and MLTSS Medicaid Document Submission Guide Member Disenrollment – Appendix G

NOTE: The Public Health Emergency officially ended on May 11, 2023, however, if your MCO has been affected by COVID-19 for any element, provide a detailed response in the narrative indicating why your MCO was unable to comply with that element. IPRO will evaluate elements within the context of potential COVID-19 impact where appropriate.

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
	5.10.2	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE ENROLLEE'S REQUEST**	
MD1	**5.10.2.A** **5.10.2.A.1**	A. An individual enrolled in a Contractor's plan may elect to change Contractors during an Annual Open Enrollment Period from October 1 to November 15. 1. All enrollees are subject to the Annual Open Enrollment Period and may initiate disenrollment from one Contractor and transfer to another Contractor for any reason during the first ninety (90) days after the latter of the date the individual is enrolled or the date they receive notice of enrollment with a new Contractor and during the period DMAHS has identified for the Annual Open Enrollment Period without cause. a. An individual may transfer from the Contractor's plan upon automatic re-enrollment if he or she was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility has caused the individual to miss the Annual Open Enrollment Period.	
MD2	**5.10.2.2**	2. An enrollee may initiate disenrollment and a transfer to another Contractor's plan at any time if they meet one of the good cause reasons defined in this contract. a. Good cause reasons for disenrollment and transfer shall include, unless otherwise defined by DMAHS: i. Failure of the Contractor to provide services including physical access to the enrollee in accordance with the terms of this contract. ii. Enrollee has filed a grievance/appeal with the Contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law. iii. Documented grievance/appeal, by the enrollee against the Contractor's plan without satisfaction. iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area. v. Poor quality of care.	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		vi. Enrollee is eligible to participate through DCP&P/DCF. vii. Enrollee has met NF LOC and is MLTSS eligible. viii. Other for cause reasons pursuant to 42 CFR 438.56.	
	5.10.3	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE CONTRACTOR'S REQUEST AND REPORTING OF ENROLLEE NON-COMPLIANCE**	
MD3	**5.10.1.A** **5.1.5.10.3.A** **5.10.3.A1**	A. Non-discrimination. Disenrollment from Contractor's plan shall not be based in whole or in part on an adverse change in the enrollee's health, on any of the factors listed in Article 7.8 (race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap or disability) or on amounts payable to the Contractor related to the enrollee's participation in the Contractor's plan. A. Criteria for Contractor Disenrollment Request. The Contractor may recommend, with written documentation to DMAHS, the disenrollment of an enrollee. (See Section B.5.1 of the Appendices, for the applicable Notification forms and amendments thereto). In no event may an enrollee be disenrolled due to health status, need for health services or a change in health status. Enrollees may be disenrolled in any of the following circumstances: 1. The Contractor becomes aware that the enrollee falls into an aid category that is not set forth in Article 5.2 of this contract, has become ineligible for enrollment pursuant to Article 5.3.1 of this contract, or has moved to a residence outside of the enrollment area covered by this contract**.**	
MD4	**5.10.3.A.2**	2. The Contractor learns that the enrollee is residing outside the State of New Jersey for more than 30 days. This does not apply to: a. situations when the enrollee is out of State for care provided/authorized by the Contractor. b. full-time students, or c. Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P.	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		For an MLTSS enrollee who has moved out of state; the Contractor must comply with all requirements set forth in article 9.3.5 and 9.3.6. In addition the Contractor shall certify that outreach to providers has occurred and a query of Medicaid/MLTSS services was completed and member has not been authorized for, or received any Medicaid services for the last 30 days. The Contractor shall then submit the LTC-50 Unable to Contact/ Inaccessible Disenrollment form to DoAS as per instructions	
MD5	**5.10.3.A.3**	3. If a Member is admitted to an out of state NF or SCNF by the Contractor, and the Member is not returning to New Jersey.	
MD6	**5.10.3.A.4**	4. Upon death of the enrollee.	
MD7	**5.10.3.A.5**	5. An enrollee is institutionalized in a facility other than a NF/SCNF.	
MD8	**5.10.3.A.6**	6. Incarceration of an enrollee (other than a DSNP enrollee) shall result in suspension of the Contractor's capitation payment and provision of Managed Care services to the enrollee from the day following the start of incarceration through the day of release. During this period, the incarcerated enrollee's benefits shall be suspended, but enrollee shall not be disenrolled. The enrollee shall remain a Member of the Contractor.	
MD9	**5.10.3.B**	B. Criteria for Non-Compliant Enrollees. The Contractor shall submit quarterly reports that includes written documentation to DMAHS of enrollees determined by the Contractor to be non-compliant. The documentation should include detail of any willful actions of the enrollee that are inconsistent with membership in the Contractor's plan. The Contractor shall provide DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include but are not limited to: persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude an enrollee's right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for non-emergency care; willful refusal to comply with reasonable approval for non-emergency care; willful refusal to comply with reasonable administrative policies of the Contractor, fraud, or making a material misrepresentation to the Contractor. In no way can this provision be applied to individuals on	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		the basis of their physical condition, utilization of services, age, socio-economic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs. (See Article 4.5 regarding special needs enrollees.)	
MD10	**5.10.2.D**	D. Effective Date. The effective date of disenrollment or transfer shall be no later than the first day of the month immediately following the full calendar month the disenrollment is initiated by DMAHS. If DMAHS fails to make a disenrollment determination for initiated disenrollments that meet the disenrollment terms under this Contract, the disenrollment is considered approved. Notwithstanding anything herein to the contrary, the remittance tape, along with any changes reflected in the register or agreed upon by DMAHS and the Contractor in writing, shall serve as official notice to the Contractor of disenrollment of an enrollee from the Contractor's plan.	(
	9.4.2	**VOLUNTARY WITHDRAWAL FROM MANAGED LONG TERM SERVICES AND SUPPORTS**	
MD11	**9.4.2.A**	A. MLTSS enrolled participants who indicate they would like to withdraw from MLTSS are required to be counseled by their Managed Care Organization Care Manager (MCO CM). This counseling shall be face-to-face with the participant. If the member declines a face-to-face visit, the counseling may occur via telephone. The MCO CM will: 1. Counsel the participant that withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 2. Ensure the participant has full understanding that if they were not receiving Medicaid State Plan services prior to enrollment into MLTSS, they may NOT be eligible for NJ FamilyCare upon withdraw from MLTSS; 3. Counsel the participant on what MLTSS and State Plan services will be lost or unavailable as a result of the withdrawal; 4. Counsel the participant on how to ensure they remain eligible to receive NJ FamilyCare;	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		5. Counsel the participant on other services or programs for which they may be eligible, including information about contacting the Aging and Disability Resource Connection (ADRC); 6. Counsel the participant on how to access MLTSS services in the future; and, 7. Ensure the participant understands the withdrawal process, timeframes, outcomes, and signs the consent form.	
MD12	**9.4.2.B**	B. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork. The participant will be asked to sign the NJ Department of Human Services Voluntary Withdrawal Form indicating their understanding and consent to withdraw from MLTSS. The voluntary withdrawal process is not to be initiated with participants who do not continue to meet the eligibility requirements for MLTSS. Instead, participants deemed not eligible for MLTSS are to follow the disenrollment and grievance and appeals guidelines.	
MD13	**9.4.2.C**	C. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the withdrawal request to the Central Office of The Division of Aging Services (DoAS), using the Voluntary Withdrawal Form found at Appendix B.5.1, within three business days of completion. DoAS will process the voluntary withdrawal within ten business days of receipt. The Contractor shall validate the disenrollment action in the eMEVS system.	
MD14	**9.4.2.D**	D. The withdrawal request must specify the member's address, phone number, and legal representative (if applicable) for potential follow up counseling by the Office of Community Choice Options (OCCO). The Program Status Code (PSC) as identified in the State's MMIS systems is to be provided by the MCO and indicated on the withdrawal request.	
MD15	**9.4.2.E**	E. The Contractor shall provide the member with the voluntary withdrawal form found in Appendix A.9.4.2 as well as a copy of the fully executed form.	
MD16	**9.4.2.F**	F. OCCO shall outreach members who are identified through the PSC as being above the FPL to ensure the member understands the withdrawal will result in loss of Medicaid coverage. OCCO shall	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		outreach within three business days of receipt of the form, document the date of discussion and confirm the member's withdrawal request. If the member indicates they wish to continue with MLTSS, then the form will be returned to the MCO Care Management designee indicating the member's request. The MCO is responsible to facilitate the reenrollment, if necessary.	
	9.4.3	**DISENROLLMENT DUE TO MEMBER NON-COMPLIANCE WITH MLTSS CARE MANAGEMENT REQUIREMENTS**	
MD17	**9.4.3.A**	A. The Contractor shall include notice of member requirement to comply with care management requirements including face to face visits and reassessment of clinical eligibility. These requirements must be reviewed during the assessment for MLTSS, if appropriate, upon enrollment, and annually thereafter.	
MD18	**9.4.3.B**	B. The Contractor shall include notice of enrollment and disenrollment processes and procedures in the Member handbook as outlined in 5.8.2.	
MD19	**9.4.3.C**	C. The Contractor shall develop and implement a policy and process for instances in which the MLTSS member declines to consent to care management services.	
MD20	**9.4.3.D**	D. Members who decline to consent to clinical eligibility reassessment or face to face visits after counseling and a minimum of two contacts to obtain consent by the Contractor or OCCO, the Contractor or OCCO, shall send written notification of the intent to terminate MLTSS eligibility no sooner than 20 business days from the date of notification due to lack of consent to care management services. The written notification of intent to request involuntary disenrollment will inform the member that: 1. The member may voluntarily change health plans if they wish to receive care management services and continue to receive MLTSS services 2. The member may voluntarily withdrawal from MLTSS if they do not wish to receive care management and MLTSS services 3. Withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 4. The individual is required to establish Medicaid status through the County Welfare Agency (CWA).	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		a. The MCO Care Manager shall provide county specific contact information and assist participant with this outreach upon request. 5. Provide information and contact numbers for community resources including the Aging and Disability Resource Connection (ADRC); 6. Provide information on how to apply for MLTSS services in the future;	
MD21	**9.4.3.E**	E. If the member requests voluntary disenrollment, the MCO shall process the request in accordance with established protocols.	
MD22	**9.4.3.F**	F. If the member fails to respond to the notification or fails to make arrangements to comply with the requirements, the MCO Care Manager Supervisor shall submit the Request for Involuntary Disenrollment Form to the Division of Aging Services (DoAS) MLTSS Operations within three business days of completion.	
MD23	**9.4.3.G**	G. Upon receipt of the Involuntary Disenrollment request, the DoAS shall send the member the Intent to Involuntarily Disenroll letter within three business days. If the participant fails to respond within ten business days, the DoAS shall send a Notice of Disenrollment from MLTSS letter which will include notice of the participant's Medicaid Fair Hearing Rights. The termination of clinical eligibility will be entered by DoAS ten business days after the date of the letter which will trigger disenrollment from MLTSS based on the standard enrollment cycle. DoAS will notify DMAHS Managed Care Account Coordinator Unit, DMAHS County Operations Office, and the MCO Care Manager designee of the clinical eligibility termination within 2 business days of entry.	
MD24	**9.4.3.H**	H. If the participant contacts DoAS or the MCO indicating they wish to continue with MLTSS and are in agreement with complying with the requirements, the recipient of the request shall notify the appropriate entity, DoAS or the MCO. The MCO MLTSS Care Manager shall initiate a face to face visit within ten (10) business days of notification.	
MD25	**9.4.3.I**	I. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork.	
MD26	**9.4.3.J**	J. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the disenrollment request to the Regional Office of Community Choice Options via the "DHS Participant Termination	

2023 New Element	Contract Reference	Contract Requirement Language	Plan Documentation (MCO please indicate page number reference to the supporting documentation)
		Request Due to Non-Compliance with Reassessment" Form within three business days of completion:	
MD27	**9.4.3.K**	K. The disenrollment request certifies that outreach, counseling, and notification has occurred without response or appeal.	
MD28	**9.4.3.L**	L. The disenrollment due to member non-compliance of determination of continued clinical eligibility is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal processes. Contact with the member and counseling must occur prior to sending the Involuntary Disenrollment. The member can stop the pending disenrollment process by consenting to the reassessment requirements.	
MD29	**4.7.4.A**	4.7.4 INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	

New Jersey Annual Assessment of MCO Operations

Core Medicaid and MLTSS Medicaid
Document Submission Guide
2023 – Appendix G1

NOTE: The Public Health Emergency officially ended on May 11, 2023, however, if your MCO has been affected by COVID-19 for any element, provide a detailed response in the narrative indicating why your MCO was unable to comply with that element. IPRO will evaluate elements within the context of potential COVID-19 impact where appropriate.

Access			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
A1	4.2.1.B	**4.2.1.B** **Emergency Services** The Contractor shall be responsible for emergency services, both within and outside the Contractor's enrollment area, as required by an enrollee in the case of an emergency. Emergency services shall also include: 1. Medical examination at an Emergency Room which is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours. 2. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect. 3. Post-Stabilization of Care. The Contractor shall comply 42 CFR 438.114(e) and 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor's network if: a. The services were pre-approved by the Contractor or its providers; or b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care; or c. The Contractor could not be contacted for pre-approval. The Contractor's financial responsibility for post-stabilization care services, if not pre-approved, ends when: i. A physician in the Contractor's network with privileges at the treating hospital assumes responsibility for the Member's care. ii. A physician in the Contractor's network assumes responsibility for the Member's care through transfer. iii. Contractor and the treating physician reach an agreement concerning the Member's care. iv. The Member is discharged.	• Policies and Procedures addressing the following: ➢ Emergency Care ➢ Access and Availability, and Primary Care Provider (PCP) After Hours Availability ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print

A2*	4.6.2.L	**4.6.2.L** **Emergency Care** The Contractor shall have methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.	▪ Policies and Procedures addressing the following for the Core Medicaid population and the MLTSS population ➢ Over/Under Utilization ▪ Over/Under Utilization Reports ▪ Provider Profiling Programs ▪ Provider Profiles ▪ ER Utilization Report ▪ ER Utilization Programs ▪ ER Initiatives Including Outcomes ▪ MLTSS Critical Incident Reports
A3	4.6.3	**4.6.3** **Referral Systems** A. The Contractor shall have a system whereby enrollees needing specialty medical, dental, behavioral health and/or long term services and supports will be referred timely and appropriately. The Contractor shall coordinate the referral process for members with substance use disorders (SUD) with the State's IME. The system shall address authorization for specific services with specific limits or authorization of treatment and management of a case when medically indicated. The Contractor shall maintain and submit a flow chart accurately describing the Contractor's referral system, including the title of the person(s) responsible for approving referrals. The following items shall be contained within the referral system: 1. Procedures for recording and tracking each authorized referral. 2. Documentation and assurance of completion of referrals. 3. Policies and procedures for identifying and rescheduling broken referral appointments with the providers and/or Contractor as appropriate. 4. Policies and procedures for accepting, resolving and responding to verbal and written Member requests for referrals made to the PCP and/or Contractor as appropriate. Such requests shall be logged and documented. Requests that cannot be decided upon immediately shall be responded to in writing no later than five (5) business days from the date of receipt of the request (with a call made to the Member on final disposition) and postmarked the next day. 5. Policies and procedures for proper notification of the Member and where applicable, authorized person, the Member's provider, and the Member's Care Manager, including notice of right to appeal and/or right to request a second opinion when services are denied.	▪ Utilization Management (UM)/Care Management/Pharmacy Referral Policy and Procedures ▪ UM Program Description ▪ Policies and Procedures addressing the following: ▪ Accepting, resolving and responding to verbal and written enrollee requests for referrals made to the PCP and/or Contractor as appropriate ▪ Proper notification of the right to appeal and/or right to request a second opinion when services are denied ▪ Special Needs ▪ Identifying and rescheduling broken referral appointments ▪ Dental Specialty Needs ▪ Long term services and supports ▪ Complex Needs Assessment (CNA) Form ▪ Case Examples ▪ Referral process for MLTSS services; i.e., PDN, TBI therapies, ALR, etc. ▪ Evidence of tracking requests for referrals (including second opinions) to ensure referral timeliness; dates and methods of member/provider/internal communication, and outcome. ▪ Evidence of tracking missed referral appointments and member/provider follow-up.

		6. A referral form which can be given to the Member or, where applicable, an authorized person to take to a specialist. 7. Referral form mailed, faxed, or sent by electronic means directly to the referral provider. 8. Telephoned authorization for urgent situations or when deemed appropriate by the Member's PCP or the Contractor. 9. Where applicable, the Contractor must also notify the Contractor Care Manager or authorized person. B. The Contractor shall provide a mechanism to assure the facilitation of referrals when traveling by an enrollee (especially when very ill) from one location to another to pick-up and deliver forms can cause undue hardship for the enrollee. Referrals from practitioners or prior authorizations by the Contractor shall be sent/processed within two (2) working days of the request, one (1) day for urgent cases. The Contractor shall have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care. C. The Contractor shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither the Contractor nor its vendor shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor its vendor shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. D. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. E. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for nonemergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee.	▪ Evidence of standing referrals to specialists in cases of ongoing specialty care. ▪ Medical and dental prior authorization procedures and guidelines for decision making. ▪ Utilization Management policies and procedures that demonstrate the UM denial process for medical and dental referrals.
A4*/**	4.5.1.F 4.8.1.A 4.8.1.E 4.8.1.J	**4.5.1.F** While the Contractor must assure that Enrollees with special needs have access to all medically necessary care, the State considers dental services to	▪ Access and Availability Policy and Procedure (GEO Access Reports) ▪ Network Development Policy and Procedure

	4.8.3 4.8.3.D	be an area meriting particular attention. The Contractor, therefore, shall accept for network participation dental providers with expertise in the dental management of Enrollees with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. **4.8.1.A** **Provider Network** The Contractor shall establish, maintain and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access (in accordance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq.) to all services covered under this contract including those with limited English proficiency or physical or mental disabilities. 1. The provider network shall consist of traditional providers for primary and specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers (FQHCs), nursing facilities, residential setting providers for recipients of MLTSS, home and community based services providers and other essential community providers/safety-net providers, and ancillary providers. 2. The provider network shall be reviewed and approved by DMAHS and the sufficiency of the number of participating providers shall be determined by DMAHS in accordance with the standards found in Article 4.8.8 "Provider Network Requirements." 3. In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, the State shall require that, in order to participate as a provider in the Contractor's network that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under NJ FamilyCare and who are enrolled with the Contractor, the provider is enrolled consistent with section 1902(kk) with DMAHS. 4. The Contractor may execute network provider agreements, pending the outcome of section 1902(kk) screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be	▪ Provider Recruitment and Retention Committee Charter ▪ Provider Directory ▪ Screen print of the Provider Directory on the MCO Website ▪ Network of dental providers who provide care to special needs enrollees.

		enrolled, or the expiration of one 120 day period without enrollment of the Provider, and notify affected Members. **4.8.1.E** The Contractor shall include in its network mental health/Substance Use Disorder providers for the Medicaid covered MH/SUD services (as stated in Article 4.1) with expertise to serve enrollees who are clients of the Division of Developmental Disabilities and providers for MH/SUD services (as stated in Article 4.4) for MLTSS Members. **4.8.1.J** The Contractor shall include in its network providers for Managed Long Term Services and Supports. The Contractor's network shall include all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0). **4.8.3** **Provider Network File Requirements** The Contractor shall provide a certified provider network file quarterly, to be reported electronically in a format and software application system determined by DMAHS that will include <u>every</u> provider including MLTSS, Behavioral Health (BH), and dental providers in the Contractor's network. The Contractor shall demonstrate its compliance with provider network requirements and how it will assure enrollee access to all benefits covered under this contract. **4.8.3.D** The quarterly provider file shall include a unique identifying number for each individual provider. The National Provider Identifier (NPI) for covered entities and the professional license number are required. Non Traditional Providers shall be identified with the provider's EIN, tax number, license number, UPIN, Medicaid provider number, Medicare provider number, and Social Security Number where applicable.	
A4a* – Core Medicaid PCPs - Adults			▪ GeoAccess Reports
A4b* – Core Medicaid PCPs – Pediatric			▪ GeoAccess Reports

A4c* – Core Medicaid Specialty Providers			▪ GeoAccess Reports
A4d* – Core Medicaid Dental/ Specialty Dental			▪ GeoAccess Reports
A4e* - Core Medicaid Hospitals			▪ GeoAccess Reports
A4f** – MLTSS Providers			▪ Provider Report/Grid of MLTSS Network
A5	4.8.1.L **4.5.3.A**	**4.8.1.L** **Enrollees with Special Needs** The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs. 1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home. 2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs. **4.5.3.A** **CLIENTS OF THE DIVISION OF DEVELOPMENTAL DISABILITIES** The Contractor shall provide all physical health services required by this contract as well as the MH/SUD services included in the Medicaid State Plan to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. The Contractor shall include in its provider network a specialized network of providers who will deliver both physical as well as	▪ Policies and Procedures addressing the following: ➢ Access and Availability ➢ Credentialing /Recredentialing ➢ Specialized Network for DDD members ▪ Provider Manual ▪ Provider application (with special needs check list and age group physician treatments) ▪ Provider Contract ▪ Provider Directory ▪ Special Needs Survey

		MH/SUD services, in accordance with Medicaid program standards to adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SUD services to clients of DDD until the behavioral health ASO is implemented.	
A6	4.8.4	**4.8.4** **Provider Directory Requirements** A. As cited by HHS in the ONC 21st Century Cures Act final rule (also published of the Federal Register) at 45 CFR170.215, Effective beginning January 1, 2021 (with enforcement date of July 1, 2021), Provider Directory Application Programming Interface (API) must be accessible via a public-facing digital endpoint on the payer's website to ensure public discovery and access. At a minimum, Contractors must make available via the Provider Directory API provider names, addresses, phone numbers, and specialties. All directory information must be made available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of Contractor receiving provider directory information or an update to the provider directory information. B. The Contractor shall maintain a web-based/on-line provider directory. DMAHS staff and HBC staff will access the web-based/on-line directory as needed to assist members. The web-based provider directories shall be maintained with updates made no later than every seven (7) days. C. Primary care providers and dentists/PCDs who will serve enrollees listed by • County, by city, by specialty • Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); website URLs as appropriate, telephone number; fax number if available; office hours at each location; whether the provider is accepting new enrollees, indicates whether a provider serves enrollees under the	▪ Provider Directory

		age of six, indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP or PCD. This shall include a separate listing of dental providers who: ➢ Provide mobile dental services through use of mobile equipment or van outside of an office/clinic in facilities, schools and residences. ➢ Provide dental services to members under the age of six (6). ➢ Provide dental services to members with intellectual and developmental disabilities. ➢ All of these listings shall be updated as needed and at a minimum quarterly. D. Contracted specialists and ancillary services providers who will serve enrollees • Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C. • MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), website URLs as appropriate, telephone number and fax number if available and information on service area and services offered and whether the provider is accepting new enrollees. • Behavioral Health Providers should be listed in on-line directory by the service description below: • Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization • Adult Mental Health Rehabilitation (AMHR) • Autism Treatment Services - ABA (Independent Practitioner) • Autism Treatment Services - ABA (Group Practice) • Autism Treatment Services - DIR (Independent Practitioner) • Autism Treatment Services - DIR (Group Practice) • Inpatient Psychiatric Hospital Care • Independent Practitioner(s) (Neuropsychologist; Psychiatry; NP Psychiatric MH; Neurology (Osteopaths Only); Psychologist) • Medication Monitoring • Outpatient Mental Health Hospital • Outpatient Mental Health Independent Clinic • Partial Care	

		SUD - Substance Use Disorder Providers should be listed in the on-line directory by the service description below: • Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 – WM • Non-Medical Detoxification / Non-Hospital based withdrawal management ASAM 3.7 – WM • Substance Use Disorder Short Term Residential (STR) ASAM 3.7 • Substance Use Disorder Long Term Residential (LTR) ASAM 3.5 • Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM • Substance Use Disorder Partial Care (PC) ASAM 2.5 • Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1 • Substance Use Disorder Outpatient (OP) ASAM 1 • Opioid Treatment Services ASAM OTP (Methadone Maintenance) • Opioid Treatment Services (Non-Methadone Maintenance) • Medication Assisted Treatment in Physician Office (w/ Navigator) • Medication Assisted Treatment in Physician Office (w/o Navigator) E. Subcontractors • Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.	
A7*	4.7.2.A.3 4.7.2.A.10 5.12 B.4.14.X.I B.4.14.XI Appendices	**4.7.2.A.3** **Appointment Availability Studies** The Contractor shall conduct a review of appointment availability and submit a report to DMAHS annually. The report must list the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review. **4.7.2.A10.Annual PCP After-Hour Availability Study** The Contractor shall conduct an annual PCP After-Hour Availability study in order to monitor availability and accessibility to primary care providers (PCPs). The study shall be designed to determine a provider's availability for telephone consultation after regular business hours. The Contractor shall survey, at a minimum, no less than 25% of its PCP network. The PCPs are to be randomly selected from the Contractor's	▪ MCO Access Standards ▪ Provider Manual ▪ Provider Directory ▪ Member Handbook ▪ Member Newsletter ▪ Policies and Procedures addressing the following: ➢ Access and Appointment Availability Standards ➢ Appointment Scheduling Assistance ➢ PCP Appointment Availability ➢ Verification of Appointment Availability ▪ PCP Appointment Availability Audit tool, results and follow-up with non-compliant providers ▪ PCP After Hours Availability Audit tool, results and follow-up with non-compliant providers ▪ Call Center Performance Measures

		provider network file. Providers shall be contacted after business hours or on weekends. Providers and staff should be asked to identify the system the office uses for telephone coverage after regular business hours. A telephone response should be considered acceptable/unacceptable based on the following criteria: Acceptable – An active provider response, such as: 1. Telephone is answered by PCP, office staff, answering service or voice mail. 2. The answering service either: • Connects the caller directly to the provider; • Contacts the PCP on behalf of the caller and the provider returns the call; or • Provides a telephone number where the PCP/covering provider can be reached. 3. The provider's answering machine message provides a telephone number to contact the PCP/covering provider. Unacceptable: 1. The answering service: • Leaves a message for the provider on the PCP/covering provider's answering machine; or • Responds in an unprofessional manner. 2. The provider's answering machine message: • Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. • Instructs the caller to leave a message for the provider. 3. No answer; 4. Listed number no longer in service; 5. Provider no longer participating in the Contractor's network; 6. On hold for longer than five (5) minutes; 7. Answering Service refuses to provide information for survey; 8. Telephone lines persistently busy despite multiple attempts to contact the provider.	▪ Call Center Monthly or Quarterly Performance Reports ▪ Telecommunications Device for the Deaf Contract

		The Contractor shall submit a report of the results of the survey and its corrective action plan to the DMAHS annually. The report shall also include the methodology and sample size used for the survey. **5.12** **Appointment Availability** The Contractor shall have policies and procedures to ensure the availability of medical, mental health/substance use disorder (for DDD clients and MLTSS Members) and dental care appointments in accordance with the following standards: A. Emergency Services. Immediately upon presentation at a service delivery site. B. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening. C. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention. D. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits. E. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral. F. Urgent Specialty Care. Within twenty-four (24) hours of referral. G. Baseline Physicals for New Adult Enrollees. Within one hundred-eighty (180) calendar days of initial enrollment. H. Baseline Physicals for New Children Enrollees and Adult Clients of DDD. Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. I. Prenatal Care. Enrollees shall be seen within the following timeframes: 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester	

		J. Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar. K. Lab and Radiology Services. Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care. L. Waiting Time in Office. Less than forty-five (45) minutes. M. Initial Pediatric Appointments. Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees. N. For dental appointments, the Contractor shall be able to provide: 1. Emergency dental treatment no later than forty-eight (48) hours or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider. 2. Urgent care appointments within three days of referral. 3. Routine non-symptomatic appointments within thirty (30) days of referral. O. For MH/SUD appointments, the Contractor shall provide: 1. Emergency services immediately upon presentation at a service delivery site. 2. Urgent care appointments within twenty-four (24) hours of the request. 3. Routine care appointments within ten (10) days of the request. P. Maximum Number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children. Q. For SSI and New Jersey Care – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment.	

		B.4.14.X.I The MCO takes steps to promote accessibility of all services offered to Members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include: 1. The points of access to primary care, behavioral health, specialty care, inpatient services and MLTSS are identified for Members. 2. At a minimum, Members are given information about: a. how to obtain services during regular hours of operations; b. how to obtain emergency and after-hours care; c. how to obtain second opinions; d. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care; e. how to select a PCP from among those accepting new enrollees; and. f. physical accessibility. **B.4.14.XI** The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and Member service lines and MLTSS contact lines). Performance on these dimensions of access are assessed against the standards.	
A8*	**4.7.4.A**	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Quality Assessment and Performance Improvement			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**

Q1*	4.6.1.A	**4.6.1.A** **Quality Assessment and Performance Improvement Plan** The Contractor shall implement and maintain a Quality Assessment and Performance Improvement (QAPI) program that is capable of producing prospective, concurrent, and retrospective analyses. Delegation of any QAPI activities shall not relieve the Contractor of its obligations to perform all QAPI functions.	▪ Quality Management/Quality Assurance Program Description ▪ QI Work Plan - Previous year and current ▪ Quality Management Program Evaluation for the previous year ▪ Entire Year of the most recent Meeting Minutes – QI, Provider Advisory, etc. ▪ Various committee meeting minutes (e.g., QI, Provider Advisory, etc.) that may demonstrate oversight.
Q2*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall carry out the activities described in its QAPI. The Contractor shall develop and submit to DMAHS and/or the EQRO at the direction of the State, an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including MLTSS-related quality activities.	▪ QI/Annual Work Plan – previous year and current ▪ Documentation demonstrating implementation and evaluation of the plan ▪ Documentation demonstrating the inclusion and implementation evaluation **of MLTSS related activities in QAPI.**
Q3*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall also prepare and submit to DMAHS and/or the EQRO at the direction of the State, an annual report on quality assurance activities which demonstrate the Contractor's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.	▪ QI Program Evaluation for previous year ▪ Annual Quality Reports
Q4*	B.4.14.II.A-G Appendix	**B.4.14.II.A-G** The Quality Assessment and Performance Improvement program has written guidelines for its quality of care studies and related activities which include: A) specification of clinical or health services delivery areas to be monitored; B) use of quality indicators; C) use of clinical care standards/practice guidelines; D) analysis of clinical care and related services; E) implementation of remedial/corrective actions; F) assessment of effectiveness of corrective actions; and G) evaluation of continuing and effectiveness of the QAPI.	▪ QI Program Description - Current ▪ QI Work Plan - Previous year and current ▪ Clinical Studies and Projects Policy and Procedure ▪ Desk top procedures
Q5*	B.4.14.II Appendix	**B.4.14.II** The Quality Assessment and Performance Improvement program objectively and systematically monitors and evaluates the quality and appropriateness of care and service, including MLTSS, to enrollees, through quality of care	▪ QI Program Description ▪ QI Work Plan

		studies and related activities, and pursues opportunities for improvement on an ongoing basis.	
Q6*	B.4.14.VI Appendix	**B.4.14.VI** The Quality Assessment and Performance Improvement program has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.	▪ Current QI Program Description ▪ Quality Management Organizational Chart ▪ Departmental job descriptions or bios
Q7*	B.4.14.VII.A B.4.14.VII.E Appendices	**B.4.14.VII.A** Participating physicians and other providers are kept informed about the written QA plan. **B.4.14.VII.E** The MCO has a description of how providers are to be involved in the design, implementation, review and follow-up of quality activities.	▪ QI Program Description ▪ Provider Manual ▪ Provider Newsletters ▪ Screen Prints of the MCO's – Provider Website ▪ PAC Charter ▪ Entire Year of the most recent Provider Advisory Committee (PAC) Meeting Minutes, Agendas, and Attendance Sheets
Q8*	B.4.14.XV.A Appendix	**B.4.14.XV.A** **Scope** The MCO shall document that it is monitoring the quality of care across all services, including MLTSS, and all treatment modalities, according to its written QAPI . (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agenda, Attendance Sheets ▪ QI Program Evaluation for previous year ▪ Member Quality of Care Compliant Analysis ▪ Quarterly and Annual Quality of Care Reports MLTSS related reports
Q9*	B.4.14.XVI Appendix	**B.4.14.XVI** The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels. A. QA information is used in recredentialing, recontracting and/or annual performance evaluations. B. QA activities are coordinated with other performance monitoring activities, including utilization management, Care Management, risk management, and resolution and monitoring of Member grievances. C. There is a linkage between QA and the other management functions of the health plan such as: 1. network changes; 2. benefits redesign; 3. medical management systems (e.g., pre-certification); 4. practice feedback to physicians; 5. patient education; 6. Member services, and;	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ QI Program Evaluation for previous year

		7. Care Management including MLTSS Care Management.	
Q10*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Quality Management			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6	**4.6** A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicaid and NJ FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports. B. The Contractor shall use its best efforts to ensure that persons and entities providing care and services for the Contractor, including long-term services and supports, in the capacity of physician, dentist, CNP/CNS, physician's assistant, CNM, or other medical service professional meet applicable licensing, certification, or qualification requirements under New Jersey law or applicable state laws in the state where service is provided, and that the functions and responsibilities of such persons and entities in providing medical, behavioral, dental and/or MLTSS care and services under this contract do not exceed those permissible under New Jersey law. This shall also include knowledge, training and experience in providing care and services to individuals with special needs as well as services provided by non-traditional MLTSS service providers.	
QM1	4.6.2.A	**4.6.2.A** **Guidelines** The Contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.	▪ Provider Manual ▪ Documentation showing how providers are notified of guideline updates including MLTSS. ▪ Provider/Member Newsletter ▪ Screen Prints of MCO Provider Website with list of Clinical Practice Guidelines ▪ Policies and Procedures addressing the following: ➢ Clinical Practice Guidelines

			▪ Individual Practice Guidelines ▪ MLTSS Guidelines
QM2	4.6.2.B	**4.6.2.B** **Treatment Protocols** The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning and contributing family and social factors.	▪ Care Management /UM Workflow Diagrams ▪ QI or UM Program Descriptions ▪ Redacted cases showing adjustments based on the enrollee's medical condition and/or contributing family and social factors ▪ Policies and Procedures addressing the following: ➢ Treatment Protocol Adjustment
QM3*	4.6.2.C	**4.6.2.C** **Monitoring** The Contractor shall have procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.	▪ Clinical Practice Guidelines ▪ HEDIS® and CAHPS® Results and Analysis ▪ Provider Profiles ▪ Utilization Reports specific to individual providers ▪ UM Program Description ▪ QI Program Description ▪ QI Work Plan ▪ Provider Profiling Program ▪ Provider files to demonstrate corrective action taken to bring practitioner into compliance with clinical practice guidelines or average utilization of services
QM4*	4.6.2.D	**4.6.2.D** **Focused Evaluations** The Contractor shall have procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied. The Contractor shall also have procedures for conducting problem-oriented clinical studies of individual care.	▪ QI Program ▪ QI Program Evaluation ▪ Quality of care case examples and tracking ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Policies and Procedures addressing the following: ➢ Quality of Care ➢ Over/Under Utilization ➢ Emergency Room Utilization ➢ Monitoring of Mortality Rates ▪ Credentialing - Covers the monitoring of quality of care concerns during the re-credentialing process ▪ Provider Monitoring Reports
QM5*	4.6.2.E	**4.6.2.E** **Follow-up** The Contractor shall have procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service ▪ Grievance Database Report/Logs ▪ Example of a Grievance Acknowledgement Letter

		prompt follow-up and resolution shall follow the standard described in Article 5.15B.	▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Blinded Case Example of Quality of Care Concern
QM6	4.6.2.F	**4.6.2.F** **Hospital Acquired Conditions and Provider–Preventable Conditions** The Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR 434, 438, and 447. Policies and procedures shall be submitted to the DMAHS for review and approval prior to implementation of the Contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes. The Contractor shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. The Contractor shall identify Other Provider-Preventable Conditions for non-payment as wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html	▪ Policies and Procedures addressing the following: ➢ Hospital Acquired Conditions ➢ Claims Payment ▪ Quality Outcomes Reports ▪ Denial Letters ▪ Educational Materials
QM7	4.6.2.G	**4.6.2.G** **Data Collection** The Contractor shall have procedures for gathering and trending data including outcome data.	▪ Policies and Procedures addressing the following: ➢ Data Collection Methods ➢ Analysis of Outcome Data ▪ Work Plans ▪ QI Program Description ▪ QI Program Evaluation ▪ Monitoring Reports ▪ ER utilization Reports ▪ Enrollee & Provider Grievances Policy and Procedure
QM8*	4.6.2.H	**4.6.2.H** **Mortality Rates** The Contractor shall review inpatient hospital mortality rates of its enrollees.	▪ Policies and Procedures addressing the following: ➢ Quality of Care ▪ Monthly Mortality Reports ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Flowcharts, Algorithm ▪ QI Program Description

			▪ QI Work Plan ▪ QI Program Evaluation ▪ Mortality Initiatives Including Outcomes
QM9*	4.6.2.I	**4.6.2.I** **Corrective Action** In compliance with 42 CFR 438.230(b)(4), the Contractor shall have procedures for informing subcontractors and providers of identified deficiencies, or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes. The Contractor shall conduct reassessments to determine if corrective action yields intended results.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service and/or Flowchart ➢ Credentialing/Recredentialing ➢ Corrective Action Plan procedure if separate from Quality of Care Policy and Procedure ▪ Request for a Corrective Action Plan (CAP) Letter to provider ▪ CAP Reminder Letters ▪ CAP Approval Letter; Closure Letter to provider ▪ Entire Year of the most recent Oversight Committee Meeting Minutes ▪ Confirmed Quality of Care Case Example
QM10	4.6.2.M	**4.6.2.M** **New Medical Technology** The Contractor shall have policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and durable medical equipment (DME).	▪ Policies and Procedures addressing the following: ➢ Technology Assessment ➢ Decisions Policy ▪ Evidence-based literature from peer-reviewed journals ▪ Provider Manual ▪ Provider Newsletters ▪ Entire Year of the most recent Oversight/New Technology Committee Meeting Minutes
QM11a*	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: “Validating Performance Improvement Projects.”	▪ Core Medicaid PIP Submission Worksheets or Other PIP Documentations ▪ Core Medicaid Special Initiatives Including Outcomes

QM11b**	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	▪ MLTSS PIP Submission Worksheets or Other PIP Documentations ▪ MLTSS Special Initiatives Including Outcomes
QM12*	4.7.2.D	**4.7.2.D** The Contractor shall conduct reviews/audits which focus on the special dental needs of enrollees with developmental disabilities. Using encounter data reflecting the utilization of dental services and other data sources, the Contractor shall measure clinical outcomes; have these outcomes evaluated by clinical experts; identify quality management tools to be applied; and recommend changes in clinical practices intended to improve the quality of dental care to enrollees with developmental disabilities.	▪ Encounter Data Reports/Other Data Reports ▪ Audit Procedure ▪ Most recent Audit Results ▪ Dental Initiatives for enrollees with Developmental Disabilities including outcomes
QM13*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
QM14	4.2.6.B.1.d	**4.2.6.B.1.d** Section 1905(r) of the Social Security Act (42 U.S.C. § 1396(d) and federal regulation 42 C.F.R. § 441.50 et seq. requires EPSDT services to include: 1. d. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by the Contractor. The following list of screening tests is not all inclusive: ▪ Hemoglobin/hematocrit/EP ▪ Urinalysis ▪ Tuberculin test – intradermal, administered annually and when medically indicated	▪ QI Evaluation ▪ Data Reports

		▪ Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child: - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age - at 18-26 months, preferably at twenty-four (24) months of age - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested ▪ Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.	
QM15	4.2.6.B. 10 a,b	**4.2.6.B. 10.a,b** **Lead Screening** The Contractor shall provide a screening program for the presence of lead toxicity in children which shall consist of two components: verbal risk assessment and blood lead testing. a. Verbal Risk Assessment – The provider shall perform a verbal risk assessment for lead toxicity at every periodic visit to children at least six (6) months and less than seventy two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions: i. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint? ii. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint? iii. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling? iv. Have any of your children or their playmates had lead poisoning? v. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community. vi. Do you give your child home or folk remedies that may contain lead? vii. Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answer to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child	▪ QI Program Description ▪ QI Evaluation ▪ Policy and Procedures

		must be tested according to age groups specified in 4.2.6.B.8.b. A child's risk category can change with each administration of the verbal risk assessment. b. <u>Blood Lead Testing</u> – All screening must be done through a blood lead level determination. The Contractor must implement a screening program to identify and treat high-risk children for lead-exposure and toxicity. The screening program shall include blood level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. A confirmatory blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, and once between 18-26 months, preferably at twenty-four (24) months If a child between the ages of twenty four (24) months and seventy two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages than stated in 4.2.6.B.1.d. i. If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed according to the schedule in 4.2.6.B.8. ii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should	

		use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing. iii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, the contractor should recommend a follow-up venous blood screening for the child, and blood lead testing for the other children and pregnant women living in the household. iv. When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, the contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation. v. When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, the Contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding the child's care, including the scheduling and results of follow-up blood lead tests. vi. When laboratory results are received, the Contractor shall require PCPs to report to the Contractor all children with blood lead levels > 5 µg/dl. Conversely, when a provider other than the PCP has reported the lead screening test to the Contractor, the Contractor shall ensure that this information is transmitted to the PCP.	
QM16	4.2.6.B.10.c	**4.2.6.B.10.c** c. On a semi-annual basis, the Contractor shall outreach, via letters and informational materials to parents/custodial caregivers of all children enrolled in the Contractor's plan who have not been screened, educating them as to the need for a lead screen and informing them how to obtain lead screening and transportation to the screening location.	▪ QI Program Description ▪ Policy and Procedures ▪ Outreach Reports ▪ Member Letters ▪ Member Educational Materials

QM17	4.2.6.B. 10d	**4.2.6.B. 10d** d. On an annual basis, the Contractor shall send letters to PCPs who have lead screening rates of less than 80% for two consecutive six-month periods, educating them on the need and their responsibility to provide lead screening services. The eligible population of children shall be identified using methodology as defined by the State.	▪ QI Program Description ▪ QI Program Evaluation ▪ Policy and Procedures ▪ Reports ▪ Provider Letters ▪ Provider Educational Materials
QM18*	4.6.2.P	**4.6.2.P** **PERFORMANCE MEASURES** The Contractor shall submit to DMAHS and/or the EQRO at the direction of the State, annually, on a date specified by the State, performance measures in accordance with the following: 1. HEDIS and NJ Specific Performance Measures. a. HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the Contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS). b. HEDIS reporting requirements shall be consistent with National Committee for Quality Assurance (NCQA) requirements found in the current HEDIS Technical Specifications. Measure rotation is not permitted. c. Electronic Submission requirements include: • HEDIS ROADMAP; • Complete HEDIS Workbook; • Interactive Data Submission System (IDSS) results; • Final Audit Report; • Source Code; • New Jersey Performance Measures results; • Member level data for select HEDIS and New Jersey Specific measures, at the discretion of the State, per EQRO file layout and submission instructions; and • A table that delineates how the populations are defined and included or excluded from performance measures following yearly guidance provided by the State and/or EQRO. d. Contractors must comply with all audit standards and requirements determined by NCQA. e. Contractors must comply with Medicaid reporting requirements, including but not limited to beneficiary category assignments as defined by the State.	▪ TPL Allocation Table ▪ Member Level Files ▪ HEDIS Roadmap ▪ Locked IDSS ▪ CSV Data File ▪ ART ▪ Final Audit Report ▪ NJ Specific Measures ▪ Source Code as needed For Core Set Measure(s): ▪ Member Level Files ▪ Source Code as needed ▪ Rate Tables ▪ Workplans and/or CAPs as needed

		f. HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook. g. New Jersey Performance Measures o Annual Preventive Dental Visits - by Dual, Disability, Other and Total categories (all duals must be included in this measure) o Age Appropriate Blood Lead Testing in Children (Multiple Lead Testing in Children through 26 months of age) h. Following yearly guidance provided by the State and/or EQRO, Contractors shall submit a Workplan by each August 15th, or other time period as requested by the DMAHS. At the State's discretion, a CAP may be required. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where services are potentially below quality standards. These performance standards will reflect the minimum acceptable service level. The performance standards may be revised as necessary to ensure that they are reasonable and accurately reflect quality expectations. The Contractor shall provide updates as requested by the State to confirm the progress of the interventions proposed to the DMAHS. 2. Core Set Measure(s) a. Following yearly guidance provided by the State and/or EQRO, the Contractor shall submit specified Core Set Measures. Electronic submission requires member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions. b. At the State's discretion, a Workplan and/or CAP may be requested of the MCOs if the performance does not reflect the minimal acceptable service level.	
QM19**	9.11.F	**9.11.F** **MLTSS Performance Measures** The Contractor shall comply with all quality metric reporting requirements, including but not limited to: a. Contractor shall utilize the State's electronic templates for Performance Measures (PMs) b. Contractor shall comply with the EQRO PM validation process c. Contractor shall comply with the State's requirements for timeliness, accuracy, and quality of report submissions.	▪ Process description for production of each MLTSS performance measure ▪ Source Code (as required) ▪ Data sources used in producing the measures ▪ Preliminary rates (sample file) for all measures ▪ Member/Event-level detail files NOTE: If the above documents have been submitted for all MLTSS PMs during the review period, do not submit again. • Report of all submissions (monthly, quarterly and annual) of MLTSS measures during the review period showing date due

			to State, date initially submitted to IPRO, and date initially submitted to State.
QM20*	4.2.6.A.6 4.2.6.A.6.a 4.2.6.A.6.b 4.2.6.B.3.a.i 4.2.6.B.3.a.ii	**4.2.6.A.6** The contractor shall provide all PCDs on a quarterly basis a list of the PCD's enrollees who have not complied with the NJFC requirement (4.2.6.B) for dental services beginning by the age of 12 months or who have not had a subsequent dental visit for oral evaluation or preventive service bi-annually. The PCD shall be required to contact these Enrollees to schedule an appointment. Documentation by the PCD of outreach efforts and responses in the patient's record is required. **4.2.6.A.6.a** When Enrollees are assigned a PCD, the list will be generated based on assignment. **4.2.6.A.6.b** When Enrollees are not assigned a PCD, the list will be generated for the dentist based on Enrollee's previous 12 months claim history. **4.2.6.B.3.a.i** A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is mandatory. **4.2.6.B.3.a.ii** Follow up at well child visits through the age of twenty (20) to determine at a minimum dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided.	▪ Provider training on Dental EPSDT requirements. ▪ Evidence of tracking Dental EPSDT services. ▪ Monitoring Reports on PCP Dental referrals based on EPSDT requirements. ▪ Referrals during PCP visits for dental follow-up. ▪ Provider Site Visit Audit Tool showing evidence of NJ Dental EPSDT requirements ▪ Most recent Medical Record Review audit findings.
Efforts to Reduce Healthcare Disparities			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
D1*	4.6.2.T.1 4.6.2.T.2	**4.6.2.T.1** The contractor shall develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following: Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including: gender, race, ethnicity, primary language, geographic location, and disability status; **4.6.2.T.2** Barrier analysis and a written action plan to address the disparities identified;	▪ Reports and Analysis conducted by the plan to identify disparities ▪ Action Plan to address disparities identified ▪ Policies and Procedures related to the identification of disparities

D2*	4.6.2.T.3	**4.6.2.T.3** Implementation of an action plan with continuous monitoring of outcomes; and	▪ Disparities in the healthcare workplan ▪ Documentation demonstrating incorporation of disparities in healthcare into plan activities
D3*	4.6.2.T.4	**4.6.2.T.4** Ongoing evaluation of the effectiveness of the action plan	▪ Policies and Procedures relating to the identification and monitoring of disparities in healthcare ▪ Disparities in the healthcare workplan ▪ Reports and Analysis conducted by the plan to re-evaluate disparities in healthcare
D4*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
D5*/**	**4.6.2.Q.5**	**4.6.2.Q.5** **Performance Improvement Project Categories.** PIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years. PIPs are to be implemented for NJ FamilyCare/Medicaid Members. At least one PIP must include activities that identify and reduce health care disparities.	▪ MCOs PIP submissions should clearly identify and reduce healthcare disparities.
Committee Structure			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CS1*	4.2.9	**4.2.9** The Contractor shall identify relevant community issues (such as TB outbreaks, violence, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and, issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be	▪ Community Needs Assessment from State and local governmental agencies ▪ QI Program Description ▪ QI Work Plan ▪ List/Schedule of Community Outreach Activities for the previous year and planned for the upcoming year ▪ Tracking Log of Completed Activities ▪ Community Needs Assessment from State and local governmental agencies

		evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include: 1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs. 2. Guidelines for Member referral. 3. Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and Contractor's guidelines for assessment and referral. 4. Embedding information about evidence-based programs in provider and Member training initiatives. 5. A tracking mechanism for referral and program completion. 6. Designation of a liaison to DHS for evidence-based disease prevention. Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. In accordance with P.L. 1968, c. 413, as amended by P.L. 2017, c. 161. Diabetes services to include but are not limited to: 1. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or Certified Nutrition Specialist (CNS) for members diagnosed with diabetes, gestational diabetes or pre-diabetes. MNT shall be consistent with evidence-based practice guidelines published by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association) . 2. Diabetes Self-Management Education (DSME) to be provided by a Certified Diabetes Educator for members diagnosed with diabetes or gestational diabetes. The DSME program shall meet current quality standards	▪ HEDIS® and CAHPS® Results and Analysis ▪ Entire year of the most recent meeting minutes showing discussion of activities

		established by either The American Association of Diabetes Educators (AADE) or The American Diabetes Association (ADA). 3. The National Diabetes Prevention Programs (NDPPs), for members diagnosed with prediabetes, which meets the standards of The National Diabetes Prevention Program established by the Center for Disease Control and Prevention (CDC). E. Signs and symptoms of common diseases and complications F. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness G. Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish). H. Prevention and treatment of alcohol and Substance Use Disorder I. Coping with losses resulting from disability or aging J. Self-care training, including self-examination K. Need for clear understanding of how to take over-the-counter and prescribed medications and the importance of coordinating all such medications L. Understanding the difference between emergent, urgent and routine health conditions M. Information and education on good oral hygiene practices and habits, and the need for regular dental visits and completion of treatment as prescribed by a dentist. N. Strategies to reduce the risk of unintentional injuries	
CS2*	4.6.1.C.1 4.6.1.C.2 4.7.2.A.6 B.4.14.IV A-E B.4.14.V Appendices	**4.6.1.C.1** **QM Committee** The Contractor shall have adequate general liability insurance for Members of the QM committee and subcommittees, if any. The committee shall include representation by providers who serve enrollees with special needs and those eligible for MLTSS. **4.6.1.C.2** **Medical Director(s):** The Contractor shall have at least one on-site Medical Director(s) currently licensed in New Jersey as a Doctor of Medicine or Doctor of Osteopathic Medicine. The Contractor shall determine the requisite number of additional Medical Director(s) necessary to ensure the delivery of integrated medical, behavioral, and dental and MLTSS services. The Contractor shall ensure that Medical Director(s) have training and experience including but not limited to, serving populations:	▪ QI Program Description ▪ QI Work Plan ▪ Quality Management/QI Committee Charter ▪ Entire Year of the most recent QI Committee Meeting Minutes, Membership List and Attendance Sheets ▪ Organizational Chart ▪ Medical Director Job Description ▪ Copy of medical director's valid and current medical license ▪ Provider Advisory Committee(PAC)/Medical Advisory Committee (MAC) membership lists ▪ Entire Year of the most recent PAC/MAC Charter, Meeting Minutes and Attendance Sheets

		• With chronic health care conditions • With co-occurring medical and behavioral health disorders • With physical and or intellectual disabilities • Who meet or are at risk to meet nursing facility level of care The Medical Director(s) shall be responsible for: a. The development, interpretation and implementation of medical, behavioral and dental health policies and procedures to guide and support the provision of medical, behavioral and dental care to enrollees; b. The development, interpretation and implementation of MLTSS policies and procedures to guide and support the provision of MLTSS to enrollees; c. Oversight of physical, behavioral and MLTSS provider recruitment activities; d. Reviewing all providers' applications and making recommendations to those with contracting authority regarding credentialing and reappointing all providers prior to the providers' contracting (or renewal of contract) with the Contractor's plan; e. Continuing surveillance of the performance of providers in their provision of health care to enrollees; f. Administration of all clinical activities of the Contractor; g. Continuous assessment and improvement of the quality of care and services provided to enrollees; h. Serving as Chairperson of Quality Management Committee; [Note: the medical director may designate another physician to serve as chairperson with prior approval from DMAHS.] i. Oversight of all provider education, in-service training and orientation; j. Assuring that adequate staff and resources are available for the provision of medical, behavioral and MLTSS services to enrollees; k. Coordinating with other Medical Directors, as necessary, to ensure integrated and coordinated medical, behavioral, dental and MLTSS services (formal and informal) for MLTSS Members; and	▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Forms showing attestations regarding ability to treat enrollees with special needs

		l. The review and approval of studies and responses to DMAHS concerning QM matters. **4.7.2.A.8** The Contractor shall submit on an annual basis to DMAHS and/or the EQRO at the direction of the State, documentation of its ongoing internal quality assurance activities. Such documentation shall include at a minimum: a. Agenda of quality assurance meetings of its medical and service professionals; and b. Attendance sheets with attendee signatures. c. Minutes of all Quality Assurance meetings, approved and signed. **B.4.14.IV** **ACTIVE QA COMMITTEE** - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO, including those QA functions regarding MLTSS. This committee or other structure has: **A. regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly. **B. established parameters for operating** - The role, structure and function of the structure/committee are specified. **C. documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions. **D. accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions. **E. membership** - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers, including MLTSS providers whose function is to support the enrollees ability to receive services in the setting of their choice. **B.4.14.V** **QAPI SUPERVISION** - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.	
CS3	4.6.2.BB	**4.6.2.BB** **Provider Advisory Committee (PAC)** The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices or provide	▪ QI Program Description ▪ QI/PAC Charter

		services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long term care needs and special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year.	▪ Entire Year of the most recent PAC Meeting Minutes, Agendas, membership Lists and Attendance Sheets ▪ Reports showing the percentage of Medicaid enrollees served by providers on the committee ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Provider Directory ▪ Provider Database File ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agendas, and Sign-In Sheets
CS4	4.6.2.BB.1	**4.6.2.BB.1** The Contractor shall have a Dental Affairs Advisory Subcommittee to give participating dental providers the opportunity to provide input to the MCO in improving dental performance rates based on CMS-416 data and quality of care.	▪ Dental Affairs Advisory Subcommittee Charter ▪ Entire Year of the most recent Dental Affairs Advisory Subcommittee Meeting Minutes, Agendas, and Attendance Sheets ▪ Dental Affairs Advisory Subcommittee Membership List ▪ Entire Year of the most recent PAC Meeting Minutes ▪ Entire Year of the most recent QI Meeting Minutes ▪ Dental initiatives including outcomes
CS5	4.6.1.C.9	**4.6.1.C.9** **Dental Director** The Contractor shall have on staff a full time (minimum 40 hours per week) Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery or a Doctor of Dental Medicine. The Dental Director must have practiced in New Jersey and shall be responsible for: a. The development, implementation and interpretation of clinical criteria and dental policies and procedures in accordance with DMHAS and NJFC regulations (N.J.A.C> 10:56, DMHAS Newsletters and the NJ FamilyCare Dental Clinical Criteria Policy) to guide and support the provision of dental care by both the Contractor and its subcontractor (if applicable) to include Provider notification of changes within 30 days. b. Oversight or shared oversight of dental provider recruitment, credentialing and re-credentialing activities with emphasis placed on the recruitment and retention of providers who treat members with special needs and/or disabilities;	▪ Dental Service Coordinator Job Description ▪ Organizational Chart ▪ Entire Year of the most recent Dental Advisory Meeting Minutes, Agenda, and Attendance Sheets

		c. Monitoring of the dental network, including review of all dental applications, to ensure network adequacy standards are met, including but not limited to provider ratios, in-county minimum, office hour minimums, and geographical accessibility standards, as set for in the Contract; d. Surveillance of the performance of providers (including the providers of their subcontractor), in their provision of dental care to enrollees. This includes but is not limited to; identifying and addressing quality of care, continuity of care (to include orthodontic treatment and other multi-visit procedures), member outreach for missing EPSDT dental periodicity services and fraud, waste and abuse; e. Administration and oversight of all dental activities of the Contractor and review all written information and materials provided to the public, Members and Providers for contract compliance; f. Where applicable, monitors IDD, SHCN and pediatric member assignment for appropriateness; g. Continuous assessment and improvement of utilization of dental services and the quality of dental care provided to Members. This shall apply to the EPSDT requirement for the first year dental visit, establishing a dental home by the age of two (2), increased utilization for pediatric preventive dental services by PCDs and oral health services by non-dental providers/medical personnel for members through age five (5).; h. Serving on the Contractor's Quality Management Committee; serving on the Contractor's credentialing committee and/or the subcontractor's credentialing committee when applicable; i. Oversight of the orientation, education, and in-service training provided to network providers to include collection of attestations for fluoride varnish application by medical personnel; j. Reviewing dental consultants for inter-rater reliability and monitor consultants' activities quarterly for compliance; k. Assuring that adequate Contractor staff and resources are available for prompt response to member and provider concerns, State referrals, requests for various deliverables and the appeals process; l. The review and approval of studies, reports and responses to DMAHS concerning utilization and Quality matters;	

		m. Representing the Contractor at Medicaid Fair Hearings and IUROs; n. Representing the Contractor at meetings of the Dental Advisory Council of DMAHS; o. If the Contractor contracts with a dental subcontractor, the Contractor's Dental Director shall provide direction and monitor its performance to ensure contract compliance and continuous quality improvement; ensure that decisions are made in a clinically-appropriate and timely manner based on the current clinical criteria policy; review all written information and materials provided to the public, Members and Providers to ensure the subcontractor complies with NJ FamilyCare policies, New Jersey State Board of Dentistry regulations, and that the Contractor's name is prominently displayed on all subcontractor materials; p. Verification on a monthly basis that dental providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs.	
CS6	4.6.2.Z	**4.6.2.Z** **Community/Health Education Advisory Committee** The Contractor shall establish and maintain a community advisory committee, consisting of Members being served by the Contractor, including MLTSS Members, authorized persons, individuals and providers with knowledge of and experience with serving elderly people, people with disabilities or people eligible for MLTSS; and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year(s).	▪ Community/Health Education Advisory Committee (HEAC) Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the Community/Health Education Advisory Committee activities ▪ QI Program Description
CS7	B.4.14.X.H	**B.4.14.X.H** Opportunity is provided for Members to offer suggestions for changes in policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ HEAC Charter ▪ Entire Year of the most recent HEAC Meeting Minutes, Attendance List, Agendas ▪ Entire Year of the most recent Committee Meeting Minutes as appropriate

			▪ Member Handbook
CS8***	4.6.2.AA	**4.6.2.AA** MLTSS Consumer Advisory Committee. The Contractor shall establish an MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, a representative group of MLTSS population participants, or individuals representing those enrollees, case managers, and others, and will address issues related to MLTSS. Contractor shall forward results and follow-up items to DMAHS on a quarterly basis.	▪ MLTSS CAC Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the MLTSS CAC activities ▪ QI Program Description
CS9*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Programs for the Elderly and Disabled			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6.2.R 4.6.2.R.1 4.6.2.R.1.g	**4.6.2.R** **Care for Persons with Disabilities and the Elderly** (Defined as SSI-Aged and New Jersey Care – Aged enrollees and SSI and New Jersey Care enrollees with disabilities). The Contractor shall have the system capability to track and report on each population separately. **4.6.2.R.1** The Contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for NJ FamilyCare elderly enrollees and enrollees with disabilities, and MLTSS Members. **4.6.2.R.1.g** The Contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit (See Article 4.7). The Quality Department shall:	
ED1	4.6.2.R.1.a	**4.6.2.R.1.a** Oversee quality of life indicators, such as: i. Degree of personal autonomy; ii. Provision of services and supports that assist people in exercising medical and social choices; iii. Self-direction of care to the greatest extent appropriate; iv. Maximum use of natural support networks; and	▪ QI Work Plan ▪ Adult and Pediatric Complex Needs Assessment (CNA) ▪ New Jersey Choice Assessment ▪ Health Risk Assessment (HRA) ▪ Quality Improvement Program Description

		v. Maintenance of optimal level of functioning.	▪ Care Management Program Description ▪ Care of Persons with Disabilities and the Elderly Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Care Management examples for the specific population
ED2	4.6.2.R.1.b	**4.6.2.R.1.b** Review persistent or significant grievances from elderly enrollees, enrollees with disabilities, and MLTSS Members or their authorized person, identified through Contractors' grievance procedures and through external oversight;	▪ Policies and procedures addressing the following: ▪ Grievances ▪ Special Needs Enrollee Grievance Summary by category and analysis of findings ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Enrollee Appeals Summary and Analysis
ED3	4.6.2.R.1.c	**4.6.2.R.1.c** Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Policies and Procedures addressing the following: ➢ Care Management of the Elderly and the Disabled ➢ Review and Revision of Policies and Procedures ▪ Quality of Care/Service Policy and Procedure ▪ QI Program Description ▪ Clinical Practice Guidelines
ED4	4.6.2.R.1.d	**4.6.2.R.1.d** Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Disabled and Elderly quarterly, semiannual or annual grievance summary and analysis ▪ Over/Under Utilization of Services Report ▪ Quality of Care/Services Reports ▪ Drug Utilization Review Report and Analysis ▪ Quality Outcomes Report and Analysis ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.1.e	**4.6.2.R.1.e** **Care for Persons with Disabilities and the Elderly** Develop written procedures and protocols for at least the following:	
ED5	4.6.2.R.1.e.i	**4.6.2.R.1.e.i** Assessing the quality of complex health care/Care Management;	▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs

			▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Adult CNA Form ▪ HRA ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED6	4.6.2.R.1.e.ii	**4.6.2.R.1.e.ii** Ensuring Contractor compliance with the Americans with Disabilities Act (ADA); and	▪ Policies and Procedures addressing the following: ➢ Americans with Disabilities Act Policy ➢ Credentialing/Recredentialing ▪ Provider Manual ▪ Provider Participating Agreement ▪ Provider Office Site Audit Tool ▪ Provider Application ▪ Corrective Action Plans for non-compliant providers ▪ Examples of provider site visit summaries ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED7	4.6.2.R.1.e.iii	**4.6.2.R.1.e.iii** Instituting effective health and function management protocols for elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the ▪ following: ➢ Care of Persons with DDD and the Elderly and the institution of effective health management protocols ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Health Risk Assessment ▪ Adult CNA Form ▪ New Jersey Choice Assessment ▪ MLTSS Level of Supervision Assessment (CRS-settings) ▪ Treatment Protocols (e.g., Milliman & Robertson® or InterQual®) ▪ Preventive Health Guidelines
ED8	4.6.2.R.1.f	**4.6.2.R.1.f** Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the following: ➢ Care of Persons with DDD and the Elderly ▪ Quality Outcomes Report and Analysis ▪ QI Program Description ▪ Provider Manual ▪ QI Program Evaluation

			▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.2	**4.6.2.R.2** **Initiatives for Aged, including MLTSS Members.** The Contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:	
ED9	4.6.2.R.2.a	**4.6.2.R.2.a** The Contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:	▪ Pneumococcal Vaccination and Influenza Immunizations Program Description ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ State Program Approval ▪ Provider Manual ▪ Provider Newsletters ▪ Pneumococcal Vaccination and Influenza Immunization Initiatives
ED10	4.6.2.R.2.a.i	**4.6.2.R.2.a.i** Development, distribution, and measurement of PCP compliance with practice guidelines;	▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Provider Specific HEDIS® Results ▪ Provider Profiling Program ▪ Provider Profiling Reports ▪ Physician Practice Overview Reports ▪ Follow-up on non-compliant providers ▪ Screen Prints
ED11	4.6.2.R.2.a.ii	**4.6.2.R.2.a.ii** Educational outreach for enrollees and practitioners;	▪ Pneumococcal vaccination and Influenza Immunizations Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives developed to address deficiencies including outcomes

ED12	4.6.2.R.2.a.iii	**4.6.2.R.2.a.iii** Access for ambulatory and homebound enrollees;	▪ Policies and Procedures addressing the following: ➢ Access to pneumococcal vaccines and influenza immunizations for homebound enrollees ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Member Handbook ▪ Screen Prints of the Enrollee Website ▪ Health Risk Assessment ▪ 3 Blinded Care Management Records
ED13	4.6.2.R.2.b	**4.6.2.R.2.b** The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, breast and prostate cancer screening. The Program shall include the following components:	▪ Preventive Cancer Screening Program Description ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ HEDIS® Results and Analysis ▪ Enrollee Preventive Health Screenings Reports including barrier analysis, initiatives developed to address deficiencies and outcomes ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ Provider Manual ▪ Provider Newsletters
ED14	4.6.2.R.2.b.i	**4.6.2.R.2.b.i** Measurement of provider compliance with performance standards;	▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints
ED15	4.6.2.R.2.b.ii	**4.6.2.R.2.b.ii** Education outreach for both enrollees and practitioners regarding preventive cancer screening services;	▪ Preventive Cancer Screening Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters

			▪ Initiatives Developed to Address Deficiencies including Outcomes
ED16	4.6.2.R.2.b.iii	**4.6.2.R.2.b.iii** Breast cancer screening in accordance with Centers for Disease Control (CDC) recommendations;	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED17	4.6.2.R.2.b.iv	**4.6.2.R.2.b.iv** Prostate cancer screening in accordance with CDC recommendations.	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED18	4.6.2.R.2.b.v	**4.6.2.R.2.b.v** Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.	▪ Provider Manual ▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Records Audit ▪ Medical Record Review Program ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider medical review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED19	4.6.2.R.2.c	**4.6.2.R.2.c** The Contractor shall develop specific programs for the care of enrollees identified with congestive heart failure, chronic obstructive lung disease (COPD), diabetes, hypertension, and depression. The program shall include the following: i. Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care; **ii.** Measurement and distribution to providers of reports on outcomes of care; iii. Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;	▪ Disease Management Program Descriptions for the following: ➢ Congestive heart failure (CHF) ➢ Chronic obstructive pulmonary disease (COPD) ➢ Diabetes ➢ Hypertension (HTN) ➢ Depression ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ CHF, COPD, Diabetes, HTN and Depression Initiatives Including Outcomes ▪ Educational Materials

		iv. Educational materials for clinical providers in the best practices of managing the disease; and v. Evaluation of effectiveness of each program by measuring outcomes of care.	
ED20	4.6.2.R.2.c.i	**4.6.2.R.2.c.i** Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ 3 Blinded Examples of Enrollee Care Plans ▪ Screen Prints
ED21	4.6.2.R.2.c.ii	**4.6.2.R.2.c.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Disease Management/Complex Case Management Annual Outcomes Report for the Specified Populations ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Profiling Program Description ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED22	4.6.2.R.2.c.iii	**4.6.2.R.2.c.iii** Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;	▪ Examples of educational materials for enrollee and caregivers ▪ Disease Management Programs for specified disease states ▪ Educational Program Evaluations
ED23	4.6.2.R.2.c.iv	**4.6.2.R.2.c.iv** Educational materials for clinical providers in the best practices of managing the disease; and	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED24	4.6.2.R.2.c.v	**4.6.2.R.2.c.v** Evaluation of effectiveness of each program by measuring outcomes of care.	▪ Disease Management Program ▪ Disease Specific Outcomes Report ▪ HEDIS® Results and Analysis ▪ Annual Disease Management Program Evaluation ▪ QI Evaluation ▪ Outcomes Report

			▪ Disease Specific Program Evaluations
ED25	4.6.2.R.2.d	**4.6.2.R.2.d** The Contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:	▪ Policies and Procedures addressing the following: ➢ Care of Persons with cognitive impairments and the elderly ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Annual Outcomes Report ▪ Annual Outcomes Analysis ▪ HRA
ED26	4.6.2.R.2.d.i	**4.6.2.R.2.d.i** Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description Care Management of enrollees with cognitive impairments ▪ 3 Blinded Examples of Enrollee Care Plans
ED27	4.6.2.R.2.d.ii	**4.6.2.R.2.d.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Outcome Reports ▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ QI Work Plan ▪ QI Evaluation ▪ Disease Management/Complex Care Management Annual Outcomes Report for the Specified Population ▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED28	4.6.2.R.2.d.iii	**4.6.2.R.2.d.iii** Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and	▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Examples of Educational Material for Enrollee and Caregivers ▪ Care Management Program Description ▪ Community Based Care Management Description

			▪ Case Examples
ED29	4.6.2.R.2.d.iv	**4.6.2.R.2.d.iv** Educational materials for clinical providers in the best practices of managing cognitive impairments.	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED30*	4.6.2.R.2.e	**4.6.2.R.2.e** **Initiatives to Prevent Long-Term Institutionalization (LTI)** Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions. This program shall include, but is not limited to, the following:	▪ LTI Program Description ▪ LTI Initiatives Including Outcomes
ED31*	4.6.2.R.2.e.i	**4.6.2.R.2.e.i** Identification of medical and social conditions that indicate risk of being institutionalized;	▪ Desk Top Procedures ▪ CNA ▪ Utilization Management Process Flowcharts ▪ Risk Assessments ▪ Redacted cases of Identification of At-risk Enrollees
ED32*	4.6.2.R.2.e.ii	**4.6.2.R.2.e.ii** Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management Program Description ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Utilization Management cases ▪ Examples of Care Plans ▪ Provider Communications ▪ Desk-Top Procedures ▪ Utilization Management/Case Management Notes ▪ Provider Programs addressing the prevention of LTI
ED33*	4.6.2.R.2.e.iii	**4.6.2.R.2.e.iii** Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Protocols addressing preventive services for at-risk enrollees ▪ CNA ▪ HRA ▪ UM Cases ▪ Blinded Enrollee Care Plans ▪ Prevention of LTI Desk-Top Procedures

ED34*	4.6.2.R.2.e.iv	**4.6.2.R.2.e.iv** Provision of home/community services covered by the Contractor.	▪ Policies and Procedures addressing the following: ➢ Home Care and Private Duty Nursing ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Referral Desk-Top Procedure ▪ CNA ▪ Blinded Enrollee Care Plan ▪ Blinded Case File
ED35	4.6.2.R.2.f	**4.6.2.R.2.f** **Abuse and Neglect Identification Initiative** Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Care Management ▪ Risk Assessments ▪ CNA ▪ Employee Training ▪ Blinded Case Example showing suspected abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ MLTSS Member training on Abuse/Neglect identification and reporting.
ED36	4.6.2.R.2.f.i	**4.6.2.R.2.f.i** Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Diagnostic tools for identifying enrollee abuse and neglect ▪ Customer Service Script ▪ Customer Service Education related to potential abuse and neglect ▪ Data Triggers
ED37	4.6.2.R.2.f.ii	**4.6.2.R.2.f.ii** Protocols and interventions to treat abuse and neglect of enrollees, including ongoing evaluation of the effectiveness of these protocols and interventions; and	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Abuse and Neglect Protocols

			▪ Case Management file of an enrollee that has had confirmed abuse and neglect ▪ Descriptions of interventions for treating abuse and neglect ▪ Program Evaluation ▪ Care Management Program Description ▪ Community Based Care Management Description
ED38	4.6.2.R.2.f.iii 4.6.2.R.2.f.iv	**4.6.2.R.2.f.iii** Coordination of these efforts through the PCP. **4.6.2.R.2.f.iv** Reporting of MLTSS-related critical incidents in accordance with Article 9.	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ Case example of confirmed abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Educational Materials ▪ CI reporting procedures and reports
Sub-heading	4.6.2.S	**4.6.2.S** For the elderly, enrollees with disabilities, and MLTSS Members, the Contractor shall monitor, evaluate and report on Member outcomes at least annually. The Contractor shall have the system capability to track and report on each population separately, and make available the results of the evaluation to DMAHS during the annual assessment audits. (See Article 4.7). The Contractor shall include of the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and Care Management, and other activities as indicated:	
ED39*	4.6.2.S.1	**4.6.2.S.1** Aspiration pneumonia	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Aspiration pneumonia Initiatives Including Outcomes
ED40*	4.6.2.S.2	**4.6.2.S.2** Injuries, fractures, and contusions	▪ Outcome Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials

			▪ Injuries, fractures, and contusions Initiatives Including Outcomes
ED41*	4.6.2.S.3	**4.6.2.S.3** Decubiti	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Decubiti Initiatives Including Outcomes
ED42*	4.6.2.S.4	**4.6.2.S.4** Seizure management	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Seizure Management Initiatives Including Outcomes
ED43**	9.7.5	**9.7.5** **Nursing Facility Diversion** A. The Contractor shall develop and implement a nursing facility diversion process that shall be approved by the State and CMS prior to implementation. The nursing facility diversion plan shall include, but not be limited to the following provisions: 1. Comprehensive clinical assessment process that identifies Members' health care and service needs; 2. Options Counseling process that ensures Members are educated on the full range of LTSS and offered a choice of care (institutional/home and community based services) and option to choose MLTSS or PACE (if available); and 3. A person-centered Plan of Care (POC) approach is implemented; 4. Monitoring hospitalizations, short term NF stays and identifying issues and strategies to improve diversion outcomes, and B. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary. The Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified below: 1. MLTSS members who request admission to a nursing facility for custodial care;	▪ State approved Nursing Facility Diversion program which includes: ▪ Identification of members for inclusion in the program ▪ Clinical assessment process ▪ Education to members regarding the process

		2. MLTSS members residing in the community who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services; 3. MLTSS members that the Contractor becomes aware are admitted to an inpatient hospital and who are not residents of a nursing facility.	
ED44*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Provider Training and Performance

2023 Element	Contract Reference	Contract Requirement Language	Documentation Examples
PT1	3.7.1.A.1 4.6.2.V 4.6.4.A.3 7.24.D 7.24.E	**3.7.1.A.1** The system shall provide reports to monitor and identify deviations of patterns of treatment from established standards or norms and established baselines. These reports shall profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals. **4.6.2.V** **Provider Performance Measures** The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. Data shall be supplied to providers for their management activities. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate: 1. Resource utilization of services, specialty and ancillary services; 2. Clinical performance measures on outcomes of care; 3. Maintenance and preventive services; 4. Enrollee experience and perceptions of service delivery; and 5. Access.	▪ Policies and Procedures addressing the following: ➢ Provider Profiling including panel size requirements ▪ Provider Profiling Program Description ▪ Most recent Provider Profile Results ▪ Cover letter for Provider Profiling ▪ Utilization of Special Services Report (MRI, CT SCAN, etc.) ▪ Various data including ER, Drug and Dental Services Utilization ▪ HEDIS® Results and Analysis ▪ EPSDT Monitoring ▪ Outcomes Reports ▪ CAHPS® Reports ▪ Member Grievance Analysis Reports ▪ Access Reports ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)

		4.6.4.A.3 **Data Collection and Reporting** The plan shall provide for systematic utilization data collection and analysis, including profiling of provider utilization patterns and patient results. The Contractor must use aggregate data to establish utilization patterns, allow for trend analysis, and develop statistical profiles of both individual providers and all network providers. Such data shall be regularly reported to the Contractor management and Contractor providers. The plan shall also provide for interpretation of the data to providers. **7.24.D** The Contractor shall provide its primary care practitioners with quarterly utilization data within forty-five (45) days of the end of the program quarter comparing the average medical care utilization data of their enrollees to the average medical care utilization data of other managed care enrollees. These data shall include, but not be limited to, utilization information on enrollee encounters with PCPs, children who have not received an EPSDT examination or a blood lead screening, specialty claims, prescriptions, inpatient stays, and emergency room use. **7.24.E** The Contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians and other health care practitioners participate. The Contractor shall review and assess data using statistically valid sampling techniques including, but not limited to, the following: Primary care practitioner audits; specialty audits; inpatient mortality audits; quality of care and provider performance assessments; quality assurance referrals; credentialing and recredentialing; verification of encounter reporting rates; quality assurance committee and subcommittee meeting agendas and minutes; enrollee grievances, appeals, and follow-up actions; providers identified for trending and sanctioning, including providers with low blood lead screening rates; special quality assurance studies or projects; prospective, concurrent, and retrospective utilization reviews of inpatient hospital stays; and denials of off-formulary drug requests.	
PT2	4.6.1.C.4	**4.6.1.C.4** Medical Record standards shall address **Medical, Behavioral, Dental**, and **MLTSS** records. Records shall also contain notation of any cultural/linguistic needs of the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Dental Record Documentation Standards ➢ Medical Records Audit ▪ Provider Manual

			▪ Medical and Dental Record Review Programs ▪ Medical and Dental Record Review Audit Tools ▪ Most recent Medical and Dental Record Review Audit Findings ▪ Provider medical/dental review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
PT3	4.6.2.K	**4.6.2.K** **Ethical Issues** The Contractor shall comply and monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including, but not limited to: ▪ Advance Directives, ▪ Family Planning services for minors, and ▪ Other issues as identified. The Contractor shall submit a report within thirty (30) days to DMAHS with changes or updates to the policies.	▪ Policies and Procedures addressing the following: ➢ Medical Records Documentation Standards ➢ Treatment of Minors ➢ Medical Records Audit ➢ Advance Directives ➢ Medical Records Standards ▪ Most recent Medical Records Audit findings ▪ Provider Manual ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
PT4	4.6.2.N	**4.6.2.N** **Informed Consent** The Contractor is required and shall require all participating providers to comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers. Copies of the forms are included in Section B.4.15 of the Appendices.	▪ Policies and Procedures addressing the following: ➢ Informed Consent ➢ Informed Consent for hysterectomies and sterilizations ▪ Examples of Consent Forms with instructions ▪ Provider Manual ▪ Monitoring Procedures ▪ Claims Denial Logs ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT5*	4.7.2.E	**4.7.2.E** The Contractor shall produce reports of all PCPs in its network (regardless of panel size), who are treating children under 21 years old, that provide information to the PCPs of underutilization or no utilization of their enrollee	▪ Provider Profiling Program ▪ Provider Profiling Procedures ▪ Provider Profiles ▪ EPSDT Monitoring

		panel Members as compared to Early Periodic Screening and Diagnostic Testing (EPSDT) utilization requirements.	▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT6	6.3.A	**6.3.A** **Provider Education and Training** A. Initial Training. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants. Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups.	▪ Policies and Procedures addressing the following: ➢ Provider Education ▪ Provider Training Overview/Program ▪ Provider Toolkit/Training Curriculum ▪ Signed Acknowledgement of Training Forms ▪ Training Attendance Forms or Learning Management System (LMS) attendance reports ▪ Provider Manual ▪ Dental Services Provider Manual ▪ Medical and Dental Provider Welcome Letters ▪ PowerPoint Presentations ▪ Tracking Logs for provider trainings
PT7	6.3.B	**6.3.B** **Ongoing Training** The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT8*	B.4.14.XII.A Appendix	**B.4.14.XII.A** **Accessibility and Availability of Medical Records** 1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof. 2. Records are available to providers at each encounter. 3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical and service records.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Record Accessibility and Availability ▪ Provider Participation Agreement ▪ Provider Manual ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Medical Record Review Audit Tool

			▪ Most recent Medical Record Review Audit Findings ▪ Provider Review Results Notification Letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)
PT9	B.4.14.X.K Appendix	**B.4.14.X.K** The organization acts to ensure that the confidentiality of specified patient information and records is protected. 1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records. 2. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas. 3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization. 4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless: a. it is required by law; b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; c. it is necessary in compelling circumstances to protect the health or safety of an individual. 5. Any release of information in response to a court order is reported to the patient in a timely manner. 6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.	▪ Policies and procedure addressing the following: ➢ Privacy and Confidentiality ➢ Medical Record Storage ➢ Medical Record Standards ➢ Medical Record Accessibility and Availability ▪ Compliance Program Description ▪ Provider Manual ▪ Provider Agreement ▪ Medical Record Audit Tool ▪ Most recent Medical Record Review Audit findings ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Provider review results notification letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)
PT10**	6.3.C	**6.3.C** MLTSS Provider Education and Training 1. The Contractor shall work with the State and other contracted MCOs to establish and conduct universal MLTSS provider training. 2. The training curriculum shall include written materials for nursing facilities, assisted living and HCBS providers. This standardized curriculum shall address	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints

		at a minimum the credentialing processes, service authorizations, continuity of care, community resources, options counseling, claims processes, cultural competency and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board. 3. The Contractor shall conduct provider training with all new MLTSS providers and on an ongoing basis as needed.	▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT11*	4.7.4	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Satisfaction			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
S1*	4.6.2.W	**4.6.2.W** **Member Satisfaction** The State will assess Member satisfaction of Contractor services via the Contractor's adult and child Medicaid Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey version 5.1H, or the version required for NCQA accreditation, including supplemental questions to be done at the discretion of the State. The Contractor must administer the entire adult and child CAHPS surveys without amendment and follow the instructions contained in the NCQA Specifications for Survey Measures for the current HEDIS year. The Contractor shall fully cooperate with its independent survey administrator such that the MCO's final, analyzed survey results shall be available to the State and/or its designee by June 15th of each contract year.	▪ MCO CAHPS® analysis including improvement actions ▪ State communications regarding results
S2	4.6.2.W	**4.6.2.W** On an annual basis, the Contractor must also ensure that its independent survey administrator submits the final CAHPS raw data to the Agency for Healthcare Research and Quality (AHRQ), and/or entity responsible for maintaining the national CAHPS database and authorizes its use for State level reporting.	▪ Corrective Action Plans ▪ Acknowledgement of receipt of submitted corrective action plans from the State ▪ Monitoring of corrective action ▪ Outcome Reports ▪ Quality Improvement Work Plan

		Contractors shall submit a Workplan by August 15th, or other time period as requested by the DMAHS. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where consumer satisfaction is potentially below quality standards. At the State's discretion, a CAP may be required. The Contractor shall submit corrective actions in a format approved by the State, to identify leading sources of enrollee dissatisfaction, specify additional measurement or intervention efforts developed to address enrollee dissatisfaction, and a timeline indicating when such activities will be completed. Upon the State's request, a status report on the additional measurement or intervention efforts shall be submitted by the Contractor to the State by a date specified by DMAHS. Additionally, for any CAHPS Survey or other member satisfaction survey conducted by the State and/or its designee, on behalf of the State, the Contractor and/or its vendor shall fully cooperate with the State and/or its designee, and make available all survey related data in a timely manner. Results will be shared with the MCOs, and at the discretion of the State, a Workplan may be requested for areas of enrollee dissatisfaction. If the Contractor conducts a Member satisfaction survey of its own, it shall send to DMAHS the results of the survey.	
S3	B.4.14.X.M Appendix	**B.4.14.X.M** **Assessment of Member Satisfaction** If the organization conducts periodic surveys of Member satisfaction with its services, including MLTSS, the following must be included in the surveys. 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors, specialists, MLTSS providers who are trained and experienced in treating people with disabilities. 2. The surveys assess at least a sample of: a. all Medicaid Members; b. Medicaid Member requests to change practitioners and/or facilities; and c. disenrollment by Medicaid Members; and d. enrollees receiving MLTSS. 3. As a result of the surveys, the organization: a. identifies and investigates sources of dissatisfaction; b. outlines action steps to follow-up on the findings; and c. informs practitioners and providers of assessment results.	Enrollee Satisfaction Survey Results performed by the MCO including those for targeted populations

		4. The organization reevaluates the effects of the above activities.	
S4*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
S5*	5.16.1.X.1	**5.16.1.X.1** **Periodic Survey of Enrollees** The Contractor shall quarterly survey new enrollees, in person, by phone, or other means, on a random basis to verify the enrollees' understanding of the Contractor's procedures and services availability. Results of the surveys shall be made available to DMAHS and/or the EQRO at the direction of the State for review on request at regularly scheduled on site visits.	▪ Results of surveys performed by the MCOs. ▪ Quarterly breakout of number of surveys fielded.
Enrollee Rights and Responsibilities			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
ER1	B.4.14.X.A B.4.14.X.C Appendices	**B.4.14.X.A** **Written Policy on Enrollee Rights** The organization shall have a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of Members: **<u>Enrollee Rights</u>** 1. to be treated with respect, dignity, and need for privacy; 2. to be provided with information about the organization, its services, the practitioners providing care, and Members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed; 3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners; 4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence; 5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers; 6. to formulate advance directives; 7. to have access to his/her medical records in accordance with applicable Federal and State laws; 8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect; 9. to be free of hazardous procedures; 10. to receive information on available treatment options or alternative courses of care; 11. to refuse treatment and be informed of the consequences of such refusal; and 12. to have services provided that promote a meaningful quality of life and autonomy for Members, independent living in Members' homes and other community settings as long as medically and socially feasible, and preservation and support of Members' natural support systems. **B.4.14.X.C** **Written Policy on Enrollee Responsibilities** The MCO shall have a written policy that addressees Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for: 1. providing, to the extent possible, information needed by professional staff in caring for the Member; and 2. following instructions and guidelines given by those providing health care services.	
ER2	B.4.14.X.E Appendix	**B.4.14.X.E** **Communication of policies to providers and organization staff** The MCO shall assure a copy of the organization's policies on Members' rights and responsibilities is provided to all participating providers annually. The MCO must monitor and promote compliance with the policies by the Contractor's staff and affiliated providers.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO provider Website Screen Prints ▪ Monitoring Procedures
ER3*	B.4.14.X.F Appendix	**B.4.14.X.F** **Communication of policies to enrollees/Members** Upon enrollment and annually thereafter, Members are provided a written statement that includes information on the following:	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ Website Screen Prints ▪ Member Letters

		1. rights and responsibilities of Members including the specific informational requirements of this section; 2. benefits and services, including MLTSS, included and excluded as a condition of membership, and how to obtain them, including a description of: a. procedures for obtaining services, including MLTSS, including authorization requirements; b. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; c. procedures for obtaining services covered by the Medicaid fee-for-service program; d. the procedures for obtaining out-of-area coverage; and e. policies on referrals for specialty and ancillary care. 3. provisions for after-hours and emergency coverage and for MLTSS Members provision of key contact information such as the emergency after hours number with immediate access to a Contractor's staff Member who has access to the Member's plan of care and who can make immediate service authorizations and perform care coordination functions; 4. the organization's policy and procedures on referrals for specialty care, ancillary services and MLTSS; 5. charges to Members, if applicable, including: a) policy on payment of charges; b) co-payments, patient pay liability and fees for which the Member is responsible; and c) what to do if a Member receives a bill for services or is non-compliant with payment of co-payments, patient pay liabilities or other fees. 6. procedures for notifying those Members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers. 7. procedures for appealing decisions adversely affecting the Member's coverage, benefits, or relationship to the organization; 8. procedures for changing providers; 9. procedures for disenrollment; and 10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.	
ER4	B.4.14.X.J Appendix	**B.4.14.X.J** **Written information for Members -**. 1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood at a 5th grade reading level using a font size no smaller than 12 point. All written materials for potential enrollees	▪ Enrollee educational materials in different languages ▪ Approval letters from the State on enrollee educational literature ▪ Population Study Results ▪ Written information in various languages

		and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point. 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.	▪ Readability Scores
ER5	B.4.14.X.L Appendix	**B.4.14.X.L** **Treatment of Minors and Individuals with Disabilities -** The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.	▪ Policies and Procedures addressing the following: ➢ Treatment of Minors and Individuals with Disabilities ▪ Program Descriptions for the following: ➢ Care Management ➢ Quality Improvement ➢ Utilization Management
ER6**	B.4.14.X.B B.4.14.X.D Appendices	**B.4.14.X.B** **Written policy on MLTSS Member rights** - The organization has a written policy that recognizes the following rights of MLTSS Members: 1. To request and receive information on choice of services available; 2. Have access to and choice of qualified service providers; 3. Be informed of your rights prior to receiving chosen and approved services; 4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability; 5. Have access to appropriate services that support your health and welfare; 6. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made; 7. To make decisions concerning your care needs; 8. Participate in the development of and changes to the Plan of Care; 9. Request changes in services at any time, including add, increase, decrease or discontinue; 10. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under the Plan of Care; 11. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers; 12. Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings;	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		13. Be informed of all the covered/required services you are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility; 14. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment. 15. Have your health plan protect and promote your ability to exercise all rights identified in this document. 16. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian. **B.4.14.X.D** **Written policy on MLTSS Member responsibilities** - The organization has a written policy that addressees Members' responsibility for cooperating with those providing services. This written policy addresses Members' responsibility for: 1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care; 2. Understand your health care needs and work with your Care Manager to develop or change goals and services; 3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services; 4. Ask questions when additional understanding is needed; 5. Understand the risks associated with your decisions about care; 6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager; 7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and 8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).	
ER7**	4.6.1.B.2	**4.6.1.B.2** Provide for MLTSS to allow an individual to maintain themselves in the least restrictive, most integrated setting of their choice, to the extent possible. Such service provision shall promote the enrollee's ability to age in place through coordination of formal and informal supports to address the assessed needs of the individual.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ MLTSS Member Handbook ▪ Care Management

ER8*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Credentialing and Re-credentialing

2023 Element	Contract Reference	Contract Requirement Language	Documentation Examples
CR1	**4.8.5.C**	**4.8.5.C** C. The Contractor shall collect and maintain, as part of its credentialing process, through special survey process, or other means information from licensed practitioners including pediatricians and pediatric subspecialists about the nature and extent of their experience in serving children with special health care needs including developmental disabilities.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Process for collecting data on a provider's experience in treating children with special healthcare needs including how it maintains and updates the information ▪ Survey for collecting provider experience in treating children with special healthcare needs including examples ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness
CR2*	4.6.1.C.5	**4.6.1.C.5** Provider Credentialing. New Jersey requires a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Before any provider/subcontractor may become part of the Contractor's network, that provider/subcontractor shall be credentialed by the Contractor. The Contractor must comply with N.J.A.C. 11:24C-1 et seq. and Standard IX of New Jersey QAPI Standards, (Section B.4.14 of the Appendices). Additionally, the Contractor's credentialing procedures shall include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The Contractor shall obtain federal and State lists of suspended/debarred providers	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Ongoing monitoring of State and federal sanctions and suspensions ▪ File review of provider terminated from MCO due to suspension of licensure to practice by CMS or the State of New Jersey ▪ Monitoring of MLTSS providers for suspension

		from the appropriate agencies and comply with the specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35 and found at B.7.35. The Contractor shall ensure providers comply with N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional as well as finger-print based background check for all Providers and their employees who provide face-to-face services to Members, when required by statute or regulation. The Contractor's process for credentialing shall include notification to providers of errors in the credentialing application within three (3) business days of receipt. The Contractor's credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.	
Sub-heading	B.4.14.IX Appendix	**B.4.14.IX** **Credentialing and Re-credentialing** The QAPI contains the following provisions to determine whether physicians, other health care professionals and other providers of services to the Contractor's enrollees meet all applicable state licensing standards, Contractor participation or credentialing criteria and are qualified to provide the care or services for which they have been contracted. (See Article 3.3.2, 4.6.1, 4.8.5, and 7.4E for additional detail regarding credentialing and recredentialing.)	
CR3	B.4.14.IX.A Appendix	**B.4.14.IX.A** **Written Policies and Procedures** The managed care organization has, at a minimum, written policies and procedures consistent with NCQA standards and State requirements, to address the following: 1. Types of providers, including organizational providers such as Hospitals, Home Health Agencies, NFs, SCNFs, Free-standing surgical centers, ambulatory care centers, inpatient Behavioral Health providers, and residential care settings, to credential and (re)credential, 2. The verification sources used, 3. Criteria for (re)credentialing, 4. Process for making (re)credentialing decisions, 5. Process for managing credentialing files that meet established criteria, 6. Process for delegating credentialing activities, 7. Process for ensuring (re)credentialing activity is conducted in a non-discriminatory manner, 8. Process for notifying providers if information collected during the (re)credentialing process substantially varies from information they provided as part of the (re)credential process,	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing

		9. Process for ensuring providers are notified of the (re)credentialing decision within 60 days of the Committee's decision, 10. Medical Director or other designated physician's direct responsibility and participation in the credentialing program, 11. Process for ensuring confidentiality of information obtained in the (re)credentialing process, except as otherwise provided by law, 12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including education, training, board certification and specialty and 13. Process for ensuring that organizational and non-traditional providers are: • In good standing with State and Federal regulatory bodies • Reviewed and approved by a recognized accrediting body, based on requirements outlined in the MLTSS Services Dictionary found in Appendix B.9.0.	
CR4	B.4.14.IX.B Appendix	**B.4.14.IX.B** **Oversight by Governing Body** The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Quality Improvement Program Description ▪ Credentialing/Re-credentialing Committee Charter ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing process including timeliness
CR5	B.4.14.IX.C Appendix	**B.4.14.IX.C** **Credentialing Entity** The plan shall designate a credentialing committee or other peer review body that includes participating providers from the Contractor's network, which makes recommendations regarding credentialing decisions.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing/Re-credentialing Committee Charter ▪ Entire Year of the most recent Credentialing/ Re-credentialing Committee Meeting Minutes
CR6	B.4.14.IX.D Appendix	**B.4.14.IX.D** **Scope** The plan identifies those providers who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, behavioral health clinicians, facilities and providers of MLTSS included in the Contractor's literature for Members, as an indication of those providers whose service to Members is contracted or anticipated.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing Committee Charter

CR7	B.4.14.IX.E Appendix	**B.4.14.IX.E** **Process** The initial credentialing process obtains and reviews verification of the following information, at a minimum: 1. the provider holds a current valid license to practice; 2. a dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it; 3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable; 4. work history; 5. professional liability claims history; 6. good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.) 7. the providers hold current, adequate malpractice insurance according to the plan's policy; 8. any revocation or suspension of a State license or DEA number; 9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and 10. any censure by the State or County Medical Association. 11. The organization requests information on the provider from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate licensing board, depending on the provider type. 12. The application process includes a statement by the applicant regarding: a. any physical or mental health problems that may affect current ability to provide health care; b. any history of chemical dependency/ substance use disorder; c. history of loss of license and/or felony convictions; d. history of loss or limitation of hospital privileges or disciplinary activity; and e. an attestation to correctness/ completeness of the applications. This information should be used to evaluate the practitioner's current ability to practice. 13. There is an attestation from each potential primary care provider's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing Process ▪ Credentialing Desk-Top Procedure ▪ Credentialing Application ▪ Practitioner Office Site Audit Tool ▪ Regulatory and Accreditation Verification Source Table ▪ Documentation showing monitoring of the credentialing timeliness

CR8	B.4.14.IX.F Appendix	**B.4.14.IX.F** **Re-credentialing** A process for the periodic re-verification of credentials (re-credentialing, reappointment, or recertification) described in the organization's policies and procedures. 1. There is evidence that the procedure is implemented at least every three years or more frequently, as necessary, to be in accordance with the providers' licensing requirements. 2. The Contractor shall develop and implement a mechanism for monitoring of critical incident events and grievances related to the care and/or services received that identified trends and determine a threshold at which an off-cycle re-credentialing event would be triggered. 3. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all providers, to decide whether to renew the participating provider agreement. At a minimum, the re-credentialing, recertification or reappointment process is organized to verify current standing on items listed in "E-1" through "E-7" above and item "E-12" as well. 4. The re-credentialing, recertification or reappointment process also includes review of data from: a. Member grievances; b. results of quality reviews; c. performance indicators; d. utilization management; e. critical incidents; and f. re-verifications of hospital privileges and current licensure.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Re-credentialing Process ▪ Re-credentialing Desk Top Procedures ▪ Documentation showing monitoring of re-credentialing timeliness ➢ Ongoing monitoring of critical incidents and grievances and process to trigger off-cycle recredentialing Practitioner-Specific: ➢ Member Grievance Reports ➢ Quality of Care Concerns ➢ Performance Indicators ➢ Utilization Management ➢ Member Satisfaction ➢ Critical incident report monitoring
CR9***	4.6.1.C.7	**4.6.1.C.7** For MLTSS providers the Contractor shall: a. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing of MLTSS providers ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness ▪ Criminal background checks

		c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members. i. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the Criminal History Record Information (CHRI) during credentialing process. iii. At minimum, have a re-credentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI). iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs. v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI. vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must undergo state CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review. vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until	▪ Monitoring of continued licensure/and or certification ▪ Monitoring of sanctions

		appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or re-credentialing. viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from las/regulation. ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof. x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract. xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute.	
CR10*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Utilization Management

2023 Element	Contract Reference	Contract Requirement Language	Documentation Examples
UM1	4.2.4.F	**4.2.4.F** Drug Utilization Review (DUR) Program. In accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the	▪ Policies and Procedures addressing the following: ➢ Formulary Denials ➢ Prior Authorization Requests

		SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October 1, 2019, requiring the Contractor to implement provisions intended to monitor opioid and antipsychotic prescription utilization, the Contractor shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Contractor shall include review of Mental Health/Substance Use Disorder drugs, opioid and antipsychotic drugs in its DUR program. The State or its agent shall provide its expertise in developing review protocols and shall assist the Contractor in analyzing MH/SUD, opioid and antipsychotic drug utilization. Results of the review shall be provided to the State or its agent and, where applicable, to the Contractor's network providers. The State or its agent will take appropriate corrective action to report its actions and outcomes to the Contractor.	➢ Type of Drug Denials ➢ Denial Criteria ➢ That scripts written by mental health/substance use disorder providers do not require prior authorization ➢ Pharmacy Prior Authorization ▪ Drug Utilization Review Program Description ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Various retrospective reports looking at the utilization of drugs in relationship to fraud and abuse (narcotics) over/under utilization of specific drugs, and mental health/substance use disorder drugs ▪ Various reports revealing clinical conflicts as related to drug interactions, drug-allergy conflicts, drug-disease conflicts, cumulative early refill, therapeutic duplication, drug exceeding maximum daily dosage, drug under minimum daily dosage, drug-age conflict, drug-gender conflict and duration of therapy ▪ Initiatives Developed to Address Deficiencies including Outcomes
UM2	4.6.1.C.3	**4.6.1.C.3** Enrollee Rights and Responsibilities. Shall include the right to the Medicaid Fair Hearing Process for Medicaid enrollees.	▪ Policy and Procedure addressing the following: ➢ Medicaid Fair Hearing Process ➢ Adverse Determinations ➢ Member Appeals ▪ Certificate of Coverage ▪ Cited page/s in the Provider Manual ▪ MCO Website ▪ Notice of Action ▪ Member Handbook
Sub-heading	4.6.4 B.4.14.XIII Appendix	**4.6.4** **B.4.14.XIII** The Contractor shall develop a written Utilization Review Plan that includes all standards described in the NJ QAPI Standards.	

UM3	4.6.4.A B.4.14.XIII Appendix	**4.6.4.A** Utilization Review Plan. The Contractor shall develop a written Utilization Review Plan that includes all standards described in the New Jersey QAPI Standards (See Section B.4.14 of the Appendices) and the standards provided in Article 4.4 for MLTSS and DDD behavioral health utilization management. Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. **B.4.14.XIII** **A. written program description** - The organization has a written utilization management program description which includes at a minimum: • procedures to evaluate medical necessity and the criteria and tools used for MLTSS Members • procedures to evaluate functional care needs and authorize services to address those needs • information sources and the process used to review and approve the provision of services • the mechanism and metrics used to evaluate the utilization management program effectiveness **B. scope** - The program has mechanisms to detect underutilization as well as overutilization.	▪ Utilization Management Program Description ▪ QI Work Plan ▪ CAHPs reports ▪ Provider Surveys ▪ Documentation for Delegated Entities ➢ Policies and Procedures ➢ Workflows ➢ MCO's role in oversight of Delegated Entities
UM4		**In 2019, this element (UM4) was removed – Contract requirements will be addressed under UM3.**	
UM5	4.6.4.A.10	**4.6.4.A.10** **Prohibited Actions** Neither the Contractor's UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the Contractor's UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.	▪ Policies and Procedures addressing the following: ➢ Member and Provider Appeals ➢ Prior Authorizations ➢ Adverse Determinations ▪ Adverse Determination Letters ▪ Provider Manual ▪ Member Handbook
UM6	4.6.4.B	**4.6.4.B** **Prior Authorization** The Contractor shall have policies and procedures for prior-authorization and have in effect mechanisms to ensure consistent application of service criteria for authorization decisions.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ UM Program Description ➢ Clinical Criteria for UM decisions

			➢ Inter-Rater Reliability Testing Policy and Procedure ▪ Inter-Rater Reliability Testing Results
UM7	4.6.4.B	**4.6.4.B** Prior authorization shall be conducted by a currently licensed, registered or certified health care professional, including a registered nurse or a physician who is appropriately trained in the principles, procedures and standards of utilization review.	**Assessment will also include a file review to verify compliance.** **Requires a State-approved policy and procedure.** ▪ QI Program Description ▪ UM Program Description ▪ Inter-rater Reliable Policy and Procedure ▪ UM Reviewer Job Description ▪ Physician-Reviewer Job Description ▪ Resumes/Bios ▪ Pharmacy personnel making authorizations for pharmaceuticals job description
Sub-heading	4.6.4.B	**4.6.4.B** The following timeframes and requirements shall apply to all **prior authorization** determinations:	
UM8	4.6.4.B.1	**4.6.4.B.1** **Routine determinations** Prior authorization determinations for non-urgent services shall be made and a notice of approved determination provided by telephone or in writing to the provider within fourteen (14) calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352, 42 CFR 438.404(c), NJAC §11:24, and the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq . The dental prior authorization shall be active for a minimum of six (6) months.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM9	4.6.4.B.2	**4.6.4.B.2** **Urgent determinations** Prior authorization determinations for urgent services shall be made within twenty-four (24) hours of receipt of the necessary information, but no later than seventy-two (72) hours after receipt of the request for service. Written notification shall be provided in accordance with the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification

UM10	4.6.4.B.3	**4.6.4.B.3** **Determination for Services that have been delivered** Determinations involving health care services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM11	4.6.4.B.4	**4.6.4.B.4** **Adverse Determinations** A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination in all adverse determinations. A NJ licensed orthodontist shall make the final determination in all adverse determinations for comprehensive orthodontic treatment service requests.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Consultant/Medical Peer Review Process ▪ UM Program Description
UM12	4.6.4.B.5	**4.6.4.B.5** **Continued/Extended Services** A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's health care provider, by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of an enrollee currently receiving inpatient hospital service or emergency room care, the Contractor shall make the determination involving continued or extended health care services within 24 hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. For services that require multiple visits, a series of tests, etc. to complete the service, the authorized time period shall be adequate to cover the anticipated span of time that best fits the service needs and circumstances of each individual enrollee.	▪ Policies and Procedures addressing the following: ➢ Concurrent Review ➢ Authorization Timeframes ▪ Excel spreadsheet of concurrent review activity with request date, decision date, date of consultation with referring provider, date of enrollee and provider notification
UM13	4.6.4.B.6	**4.6.4.B.6** **Reconsiderations** The Contractor's policies and procedures for authorization shall include consulting with the requesting provider when appropriate. The Contractor shall have policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ UM Program Description

		provider. Determinations in such cases shall be made within the timeframes established for initial considerations.	
UM14	4.6.4.B.7	**4.6.4.B.7** The Contractor shall provide written notification to enrollees and/or, where applicable, an authorized person at the time of denial, deferral or modification of a request for prior approval to provide a medical/dental/behavioral health/MLTSS service(s) when the following conditions exist: a. The request is made by a medical/dental or other health care provider who has a formal arrangement with the Contractor to provide services to the enrollee. b. The request is made by the provider through the formal prior authorization procedures operated by the Contractor. c. The service for which prior authorization is requested is a Medicaid covered service for which the Contractor has established a prior authorization requirement. d. The prior authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring or modifying the service requested but prior to the point at which the enrollee must initiate the Contractor's appeal process.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ Notice of Action ▪ Tracking System
UM15	4.6.4.B.8	**4.6.4.B.8** **Notice of Action.** Notice of action shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. The member, member's authorized representative, and provider acting on behalf of a member with the member's written consent (if the latter is applicable) shall receive written notice of any adverse determination within two business days of said determination. The written notice shall be generated on the date of the determination. In the case of expedited appeal process, the Contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, and the enrollee (or their authorized representative) of the following: a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other coverage determination; b. The enrollee's rights to, and method for obtaining, an external (IURO) appeal and/or Fair Hearing to contest the denial, deferral or modification action; c. The enrollee's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, or a friend or other spokesperson designated in writing as an authorized representative; d. The action taken or intended to be taken by the Contractor on the request for prior authorization and the reason for such action including clinical or other rationale and the underlying contractual basis or Medicaid authority;	▪ Policies and Procedures addressing the following: ➢ Adverse Determinations ▪ Notice of Action Letter templates – Enrollee and Provider ▪ Examples of Notice of Action Letters – Enrollee and Provider

		e. The name and address of the Contractor; f. Notice of internal (Contractor) appeal rights and instructions on how to initiate such appeal; g. Notice of the availability of the clinical or other review criteria relied upon to make the determination; h. The notice to the enrollee shall inform the enrollee that he or she may file an appeal concerning the Contractor's action using the Contractor's appeal procedure prior to or concurrent with the initiation of the State hearing process; i. The Contractor shall notify enrollees, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352 42 CFR 438.404(c), and in NJAC §11:24-8.3; j. The enrollee's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal.	
UM16*/**	5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.4 4.6.4.B.5 4.6.4.B.7 4.6.4.B.8	**5.8.2.F** **Grievances and Appeals** 1. Procedures for resolving grievances, as approved by the DMAHS including a member facing explanation of the process for filing an appeal. 2. A description of the grievance/appeal procedures to be used to resolve an adverse benefit determination, including: the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in adverse benefit determination appeals; the time frames and circumstances for expedited and standard appeals; the right to appeal an adverse benefit determination; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 3. The Contractor shall notify all enrollees in their primary language of their rights to file grievances and appeals by the Contractor. 4. An explanation that, in addition to the MCO Appeal process, Medicaid/NJ FamilyCare A enrollees, and NJ FamilyCare ABP enrollees have the right to a Fair Hearing (which must be requested within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal) with DMAHS and the appeal process through the New Jersey Department of Banking and Insurance (DOBI), including instructions on the procedures involved in making such a request. 5. Notification that benefits that the Contractor seeks to reduce, suspend, or terminate will continue while an appeal is pending if the enrollee files an appeal or a request for Fair Hearing (and requests that benefits continue during the Fair Hearing) within the timeframes specified at 4.6.4.C, and that the enrollee may be required to pay the cost of services furnished while the Fair Hearing is pending if the final decision is adverse to the enrollee.	**Requires a State-approved policy and procedure addressing the grievances and appeals.** ▪ Policies and Procedures addressing the following: ➢ Prior Authorization processes ➢ Enrollee, appeals, and grievances ➢ Provider, appeals, and grievances ▪ Tracking logs ▪ Letters templates ▪ Examples of Provider/Enrollee letters ▪ Member Handbook ▪ Provider Manual

		5.15.1.A DMAHS Approval. The Contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of grievances and appeals by enrollees. The grievance and appeal policies and procedures shall be in accordance with. 42 C.F.R. 438, with the modifications that are incorporated in the contract. The Contractor shall not modify the grievance/appeal procedure without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The Contractor's grievance/appeal procedures shall provide for expeditious resolution of grievances/appeals by Contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management grievances/appeals. (For the utilization management appeal process, see Article 4.6.4C.) The Contractor shall review the grievance/appeal procedure at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure. The Contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All enrollees have available the grievance and appeal processes under the Contractor's plan, the Department of Banking and Insurance and, for certain NJ FamilyCare beneficiaries (i.e., Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees), the Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, do not have the right to a Fair Hearing. **6.5.B** Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting. **4.6.4.B.1, 2, 3, 4, 5, 7, 8: See above elements for contract language relating to UM files and appeals.**	
UM16a* Member Grievances – Core Medicaid			▪ File Review

UM16b* Provider Grievance – Core Medicaid			▪ File Review
UM16c* Member Appeals – Core Medicaid			▪ File Review
UM16d* Provider Appeals – Core Medicaid			▪ File Review
UM16e* UM – Core Medicaid			▪ File Review
UM16f** Member Grievance – MLTSS			▪ File Review
UM16g** Provider Grievance – MLTSS			▪ File Review
UM16h** Member Appeals – MLTSS			▪ File Review
UM16i** Provider Appeals – MLTSS			▪ File Review
UM16j** UM - MLTSS			▪ File Review
UM17	4.6.4.C	**4.6.4.C** **Appeal Process for UM Determinations**	▪ Policies and Procedures Addressing the following:

		The Contractor shall have policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.	➢ Prior Authorizations ➢ Addressing Timeliness of Decisions ➢ Adverse Determinations ➢ Enrollee and Provider Appeals ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Notice of Action ▪ Member Handbook ▪ Provider Manual
UM18	B.4.14.XIII.C Appendix	**B.4.14.XIII.C** **Pre-authorization and concurrent review requirements** For organizations with preauthorization or concurrent review programs: 1. The organization implements written policies and procedures, reflecting current standards of medical practice and standards of functionality for long term services and supports, for processing requests for initial authorization of services or requests for continuation of services. a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services. b) Criteria for decisions on coverage, medical and /or functional necessity and service authorization are clearly documented, are based on reasonable medical evidence, or a consensus of relevant health care professionals, or policy guidance by DMAHS and are regularly updated. c) Mechanisms are in place to ensure consistent application of review criteria and comparable decisions on service authorizations are made across reviewers, including Medical Directors. d) A clinical peer, in a same or similar specialty, reviews all decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and /or functional appropriateness. The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services, including MLTSS. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request	▪ Policies and Procedures addressing the following: ➢ Monitoring the effects of UM program using enrollee and provider satisfaction data ➢ UM program analysis using enrollee and provider satisfaction data ▪ Improvement Plans ▪ Outcome Data

		reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing. e) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. f) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process. g) Mechanisms are in effect to detect both underutilization and overutilization of services. 2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals with appropriate subject matter expertise in the populations and services being authorized. 3. Efforts are made to obtain all necessary information, including pertinent clinical and/or functional information, and consult with the treating provider as appropriate. 4. The reasons for decisions are clearly documented and available to the Member. 5. There are well-publicized and readily available appeals mechanisms for both providers and Members. Notification of a denial includes a description of how to file an appeal. 6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation. 7. There are mechanisms to evaluate the effects of the program using data on Member satisfaction, provider satisfaction or other appropriate measures. 8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.	
UM19*/**	B.9.0 MLTSS Service Dictionary for PDN services. 4.5.3.H N.J.A.C.	**B.9.0 MLTSS Service Dictionary** Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Prior Authorization ▪ Case Examples

	§10:60-5.4(b)	paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care. The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services. MLTSS Private Duty Nursing Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program. Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care **4.5.3.H** Individuals who are 20 years and older with an intellectual/developmental disability who are identified as receiving Private Duty Nursing shall be referred to the Division of Developmental Disabilities for consideration of the DDD Supports Plus Private Duty Nursing (SPPDN) program. If SPPDN is indicated the MCO shall complete a NJ Choice Assessment when the member is 20.5 years or older and submit the OCCO as assessment type "4" Supports along with the DDD determination. If the member meets Nursing Faculty Level of Care and DDD program requirements the member will be enrolled into the program. A NJ Choice assessment is required annually for all members enrolled in SPPDN program. **N.J.A.C. §10:60-5.4(b)** (b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below: 1. A requirement for all of the following medical interventions: i. dependence on mechanical ventilation; ii. the presence of an active tracheotomy; and	▪ Tracking Mechanisms ▪ Member Handbook ▪ Oversight Documentation ▪ Denial Letters ▪ New Jersey Choice Assessment Narrative ▪ Special Care Nursing Facility Level of Care Approval Request

		iii. the need for deep suctioning; or 2. A requirement for any of the following medical interventions: i. the need for around-the-clock nebulizer treatments, with chest physiotherapy; ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or iii. a seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsants.	
UM20*/**	9.6.5.E 9.6.5.I N.J.A.C. §10:60-5.5(f)3	**Private Duty Nursing Services** **9.6.5.E MLTSS** The Care Manager shall continuously assess/identify a problem or situation and take appropriate action. The Care Manager shall provide more frequent case monitoring when the Care Manager is notified of an urgent/emergent need or change of condition that may require revisions to the existing plan of care. The Care Manager shall conduct a face-to-face visit within twenty-four(24) hours when the situation resulting from the need or change of condition cannot be handled over the telephone or when the Care Manager has reason to believe the Member's well-being is at risk. **9.6.5.I** The Care Manager shall update the written plan of care, in accordance with the Member's assessed needs and goals, at each visit. The Member must indicate his/her agreement with the plan of care each time there is an increase or reduction in services. The Care Manager shall provide the Member a copy of the revised and signed plan of care. **N.J.A.C. §10:60-5.5(f) EPSDT** A nursing reassessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following: 1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services. 2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s). 3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Tracking Mechanisms ▪ Documentation Standards ▪ Care Plans ▪ Oversight Documentation ▪ MLTSS Plan of Care or Service Plans
UM21		**In 2019, this element (UM21) was removed and will no longer be reviewed.**	

UM22*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Administration and Operations

2023 Element	Contract Reference	Contract Requirement Language	Documentation Examples
AO1	4.9.3.A 4.9.3.B	**4.9.3.A** The Contractor shall comply with all the provisions of the New Jersey MCO regulations at N.J.A.C. 11.24 et seq. regarding Provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the Members receiving a course of treatment; continuity of care; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and Members who reside in the county in which the hospital is located or in an adjacent county within the Contractor's service area. **4.9.3.B** The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, at least 45 days or as soon as practicable prior to the effective date of suspension, termination, non-renewal of contract, or voluntary withdrawal, or any other form of non-participation of a provider or subcontractor from participation in this program. The Contractor's notice to DMAHS and the MFD shall include the reason for the provider's non-participation in the plan. Failure to report the information required by this section and or failure to report the information in the time period specified will subject the contractor to the provisions of Section 7.36.6 of the Contract. If the termination was "for cause", the Contractor's notice to DMAHS shall include the reasons for the termination. 1. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Member letter of specialist termination in English and Spanish ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination ▪ Notification to providers and enrollees of hospital termination/non-renewal with associated hospital termination/non-renewal date ▪ Notification to DMAHS of terminations ▪ Evidence of notification within 45 days

		2. The Contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date. 3. The Contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.	
AO2	4.9.3.C	**4.9.3.C** If a primary care provider ceases participation in the Contractor's organization, the Contractor shall provide written notice at least thirty (30) days from the date that the Contractor becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice within fifteen days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination
AO3*	5.7.A	**5.7.A** The Contractor shall have in place a Member Services Unit to coordinate and provide services to Medicaid/NJ FamilyCare managed care enrollees. The services include, but are not limited to, enrollee selection, changes, assignment, and/or reassignment of a PCP, explanation of benefits, assistance with filing and resolving inquiries, billing problems, grievances and appeals, referrals, appointment scheduling and cultural and/or linguistic needs. This unit shall also provide orientation to Contractor operations and assistance in accessing care.	▪ Customer Service Departmental Organizational Chart ▪ Customer Service Staff Job Descriptions ▪ Customer Service Department Training Manual ▪ Ongoing Training Materials ▪ Customer Service Desk-Top Procedures ▪ Customer Service Department Orientation schedules ▪ Service Standards ▪ Monitoring reports and documentation showing efforts to address identified deficiencies ▪ Review of Call Center systems
AO4	5.8.5.A 7.24.M	**5.8.5.A** Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information: 1. Name of enrollee 2. Issue date for use in automated care replacement process 3. PCP name "or your Medicare PCP" (may be affixed by sticker)	▪ Policies and Procedures addressing the following: ➢ Customer Service Department ➢ New Member Process ➢ Post Enrollment ID Card Production ▪ Customer Service Departmental ID Card Production Reports ▪ Monitoring Reports

		4. PCP phone number (may be affixed by sticker) 5. What to do in case of emergency and that no prior authorization is required 6. Relevant co-payments/personal contributions to care 7. Contractor 800 number – emergency message 8. Dental Benefit information. The contractor will provide information on the contractor ID card to assist members with obtaining information for the NJFC dental benefit. If dental services are provided through a subcontractor, both the name of the Contractor and the subcontractor must appear on the card. a. The contractor ID card includes Dental Services as a benefit on the card and a toll free contact number (may be affixed by sticker for existing members) b. For those enrollees that are assigned and change PCD and for new enrollees that are assigned a PCD, a separate ID card from the contractor shall be included in the letter that provides information for the selected or assigned PCD (dentists/dental group). It will include: 1. Name of enrollee 2. Issue Date for use in automated card replacement process 3. Primary Care dentist/office Phone Number 4. Relevant copayments/Personal Contributions to Care 5. Contractor 800 number – indicate types of assistance such as dental benefit questions/assistance 6. Subcontractor 800 number – indicate types of assistance such as assistance in locating a dentist Any additional information shall be approved by DMAHS prior to use on the ID card. **7.24.M** M. The Contractor shall, on a monthly basis, submit a report indicating all undeliverable member identification cards in the format prescribed by DMAHS. The Undeliverable ID Card Report shall be submitted to the State's Health Benefits Coordinator.	▪ Example of current ID Card ▪ Example of Dental ID Card for members with PCD
Sub-heading	4.9.6	**4.9.6** **Subcontracts:** In carrying out the terms of the contract, the Contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or administrative services as defined in Article 1. In doing so, the Contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.	
AO5	4.9.6.A - I	**4.9.6.A-I** A. All subcontracts shall be in writing and shall be submitted to DMAHS for prior approval at least 90 days prior to the anticipated implementation date. DMAHS approval shall also be contingent on regulatory agency review and approval.	▪ Provider Participation Agreement Template Letter ▪ Administrative Services Agreement between MCO and Service Provider

		B. The Department shall prior approve all provider contracts and all subcontracts. C. All provider contracts and all subcontracts shall include the terms in Section B.7.2 of the Appendices, Provider/Subcontractor Contract Provisions. D. The Contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the Contractor and the Department. E. Unless otherwise provided by law, Contractor shall not cede or otherwise transfer some or all financial risk of the Contractor to a subcontractor. F. Every third party administrator engaged by the Contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267 G. All Contractors entering into subcontracts with other entities for the provision of health care services should also comply with requirements under 42 CFR 438.6(k), 42 CFR 438.230(a),42 CFR 438.230(b)(1), (2), (3). H. All subcontractors are to comply with requirements in terms of this contract listed in 5.8.2 Enrollee Notification and Handbooks and 6.2 Provider Publications. These documents are to be subject to DMAHS review and approval following the same timelines and requirements as comparable documents produced by contractors. I. Any subcontract where the subcontractor (vendor) provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.	▪ Copies of agreements or subcontracts with other entities contracted to provide services to MCO enrollee ▪ Contracts between the MCO and subcontractor ▪ QI Program Description ▪ Annual QI Program Evaluation

AO6	7.3.A	**7.3.A** **Staffing**: The Contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The Contractor shall demonstrate to DMAHS' satisfaction that it has the necessary dedicated, non-delegable New Jersey staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum: 1. A designated administrative liaison for the Medicaid/NJ FamilyCare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative") 2. A full-time Medical Director(s) who shall be licensed as an M.D. or D.O. in New Jersey and meets the experience requirements pursuant to Article 4.6.1(C)(2). 3. A full-time senior executive dedicated to MLTSS who has at least five (5) years of experience administering managed long term care programs. Equivalent experience administering long term care programs and services, including HCBS, or in managed care may be substituted, subject to DMAHS approval. 4. A Dental Director - who shall be licensed as a DDS or DMD in New Jersey 5. A behavioral health administrator who is a New Jersey licensed social worker (LSW), licensed registered nurse (RN), clinical nurse specialist (CNS), licensed advanced practice nurse (APN), physician or psychologist with experience serving chronically ill populations with mental health and Substance Use Disorders, a minimum of three (3) years of experience serving in a managerial/leadership role and knowledge of managed care. 6. Financial officer(s) or accounting and budgeting officer 7. QM/UR coordinator who is a New Jersey-licensed registered nurse or physician 8. Prior authorization staff sufficient to authorize medical, behavioral, dental and MLTSS services twenty-four (24) hours per day/seven (7) days per week 9. A full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff. 10. A designated Care Manager or supervisor to act as administrative liaison between the Contractor and the various State entities for the MLTSS Care Management requirements set forth in this contract. At a minimum, this individual shall meet the Care Manager requirements pursuant to Article 9.5.2 and have a minimum of four (4) years experience serving enrollees receiving long term services and supports. 11. Designated Medicaid Care Manager(s) who shall be available to DMAHS medical staff to respond to medical, behavioral or MLTSS related problems, grievances, and emergent or urgent situations 12. Member services unit head	▪ Organizational Chart ▪ Individual Departmental Organizational Charts ▪ Key staff job descriptions listing essential duties and responsibilities, education, experience, required qualifications, licensure and/or certification for the position

		13. Provider services unit head as well as a provider services liaison dedicated to MLTSS. The Contractor shall identify one or more MLTSS provider representatives for MLTSS providers. MLTSS provider representative(s) shall be responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing and other MLTSS provider needs. The MLTSS provider representatives shall conduct ongoing communications with MLTSS providers through provider forums, webinars, dedicated toll-free MLTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes 14. Encounter reporting staff/claims processors supervisors 15. Grievance coordinator 16. A full-time designated MLTSS Member Representative responsible for internal representation of the interests of MLTSS Members including but not limited to input into planning and delivery of long term services and supports, participation in QM/QI activities, assistance with program monitoring and evaluation, and provision of education to enrollees, families, and providers on issues related to the MLTSS program. The MLTSS Member Representative shall assist MLTSS Members in navigating the Contractor's system. This shall include, but not be limited to, helping MLTSS Members understand and use the Contractor's system, being a resource for MLTSS Members, providing information, making referrals to appropriate Contractor staff Members, and facilitating resolution of any issues. The MLTSS Member Representative shall make recommendations to the Contractor on any changes needed to improve the Contractor's system for MLTSS Members, and participate as an ex officio Member of the Contractor's Consumer Advisory Committee. 17. A Nursing Facility Transition/Money Follows the Person program staff person possessing the skill and knowledge to assist in coordinating and facilitating Member transition from nursing facilities to the community. 18. A Participant Direction liaison who is knowledgeable in the process of service delivery through participant direction. This person will serve as the liaison between the MCO, the Member and the state to facilitate communication and ensure appropriate coordination of services. 19. Adequate administrative and support staff 20. Compliance Officer 21. A dedicated Housing Specialist(s) who shall be responsible for helping to identify, secure, and maintain community-based housing for MLTSS Members and for developing, articulating, and implementing a broader housing strategy within the Contractor to expand housing availability/options. The Housing Specialist(s) shall act as the Contractor's central housing expert(s)/resource(s), providing education and assistance to all Contractor's relevant staff (care managers and others) regarding supportive housing services and related issues for MLTSS	

		Members. The Housing Specialist(s) shall be a dedicated staff person whose primary responsibility is housing-related work. The Housing Specialist shall not be a staff person to whom housing-related work has been added to their existing responsibilities and function within the MCO. The Housing Specialist shall act as a liaison with DMAHS staff, or its designee, to receive training and capacity building assistance. The Housing Specialist(s) shall provide quarterly reports to DMAHS regarding the Contractor's progress towards identified housing goals/strategies and its quality monitoring activities. a. The Housing Specialist(s) shall have at least three (3) years' full-time experience in assisting vulnerable populations (e.g. homeless, elderly, people with disabilities, etc.) to secure accessible, affordable housing. The Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources. b. The Contractor shall provide evidence of the aforementioned qualifications for those individuals or entities hired/designated as Housing Specialist(s) if requested by DMAHS. 22. A New Jersey dedicated Pharmacy Director	
AO7	7.3.C	**7.3.C** **Training** The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. The Contractor shall ensure compliance with all mandated training programs as required by DMAHS. The Contractor shall comply with Article 9.5.3 and 9.5.4 regarding MLTSS staff training.	▪ Policies and Procedures addressing the following: ➢ Staff Selection and Placement, Retention, and Background Checks ➢ Examples of Website Training Programs Screen Print ➢ General Orientation Materials ➢ Departmental Orientation Documents ➢ Ongoing Training Documents ➢ Resumes/Bios ➢ Job Descriptions
Sub-heading	B.4.14.VIII Appendix	**B.4.14.VIII** **Delegation of QAPI Activities** The MCO remains accountable for health services management and all QAPI functions, including those pertaining to MLTSS even if certain functions are delegated to other entities.	
AO8	B.4.14.VIII.B Appendix	**B.4.14.VIII.B**	▪ Policies and Procedures addressing the following:

		The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care provided.	➢ Monitoring and Evaluating Delegated Activities ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Evidence of monitoring activities
AO9	B.4.14.VIII.C Appendix	**B.4.14.VIII.C** There is evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.	▪ Delegation Oversight Audits and findings including any corrective action ▪ Entire Year of the most recent committee oversight meeting minutes such as Credentialing Committee and Medical Management
AO10	B.4.14.VIII.D Appendix	**B.4.14.VIII.D** The organization evaluates the entity's ability to perform the delegated activities prior to delegation.	▪ Policies and Procedures addressing the following: ➢ Evaluation Prior to Delegation ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Pre-Delegation Evaluation Audit findings
AO11	B.4.14.VIII.E Appendix	**B.4.14.VIII.E** If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.	▪ Quality Improvement Program Description ▪ Credentialing Program ▪ Policies and Procedures addressing the following: ▪ Delegation Agreement Process and Structure ▪ Credentialing Delegation – Scope of Work and Performance Standards ▪ Credentialing Committee Charter ▪ Delegation Agreements ▪ Entire Year of the most recent Credentialing Committee Meeting Minutes
AO12**	4.8.1.M 4.9.2.E	**4.8.1.M** MLTSS Any Willing Provider and Any Willing Plan. The definition of MLTSS Any Willing Providers refers to any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury. The definition also applies to long term care pharmacies that apply to become network providers. These Medicaid Providers must comply with the Contractor's provider network participation requirements and are included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form which is known as	▪ Evidence of compliance with AWP requirements – procedures relating to contracting for NFs, SCNFs, ALs and CRSs; ▪ Contracts executed to serve MLTSS population ▪ Correspondence with providers requesting participation

		Any Willing Plan. The Contractor must accept all NFs, SCNFs, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Provider. Network participation of these provider types cannot be denied based on the application of a subjective standard. 1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2023, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2023. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. 2. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, performance on specified quality metrics , or other factors dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers. 3. The Any Willing Plan status also expires June 30, 2023. **4.9.2.E** **Contract Submission**: MLTSS provider contracts and subcontracts – The Contractor shall include the MLTSS Any Willing Provider (AWP) and contract term period provisions as necessary and as detailed at 4.8.1M. The Contractor shall contract with all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0) and include all required provider specification requirements. These include, but are not necessarily limited to: 1. Nursing Facility - The Contractor shall include in Custodial and Rehabilitation facility contracts, a notice requirement for the facility/provider to contact the Contractor prior to or within 24 hours of admission for authorization of care. 2. Adult Family Care a. Licensed Adult Family Care Sponsored Agency (AFC) – licensed by HFEL (Health Facilities Evaluation and Licensing) 3. Assisted Living Services (ALR, CPCH) – Assisted Living Facility a. Assisted Living Residences (ALR) b. Comprehensive Personal Care Home (CPCH) 4. Assisted Living Program (ALP) 5. TBI Behavioral Management (Group and Individual) 6. Caregiver/Participant Training 7. Cognitive Therapy (Group and Individual) 8. Community Residential Services (CRS)	

		9. Medical Day Services 10. MLTSS PCA a. The Contractor shall, in any Provider contract for personal care services, require that the increase in hourly rate above the hourly rate paid in state fiscal year 2018 be used solely to increase payments to workers who directly provide personal care services consistent with P.L. 2017, c. 239 1. b. The Contractor shall, in any Provider contract for personal care services, inform the Provider that it will be required to report to DMAHS showing compliance with the requirement to increase payments to direct care workers consistent with P.L. 2017, c. 239 2. 11. Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy (Group and Individual) 12. Private Duty Nursing (Adult) 13. Specialized Medical Equipment and Supplies and Evaluation 14. Supported Day Services 15. Non-Traditional Provider Contracts –All model contract forms with Non-Traditional providers shall be submitted on a file and use basis thirty (30) days prior to the effective date, and shall comply with all applicable State and federal laws. Services may include: Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, Medication Dispensing Devices and Monthly Monitoring, Non-Medical Transportation; Personal Emergency Response System (PERS) Device, Set Up, and Monitoring, Residential and Vehicle Modifications, Respite, Social Adult Day Care, Structured Day Program.	
AO13*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

AO14*	4.7.2.A.9	**4.7.2.A.9** **Report of Accreditation Status** a. Contractor is required to inform the State, at least annually and upon any change of accreditation, whether it has been accredited by a private independent accrediting entity. b. Contractors that have received accreditation by any private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including: i. Accreditation entity name ii. Accreditation status, survey type, and level (as applicable) iii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings, and iv. Expiration date of the accreditation. c. Contractors must make the accreditation status available on their Web sites to include: I. Whether the Contractor has been accredited by a private independent accrediting entity II. the name of the accrediting entity, accreditation program, and accreditation level (as applicable) III. Update this information annually or more frequently if that are any changes in accreditation.	▪ Evidence of annual notification to DMAHS of accreditation status, or more frequently if there are any changes in accreditation.
Management Information Systems			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	3.1.2.A	**3.1.2.A** **Timely Processing** The Contractor shall provide for timely updates and edits for all transactions on a schedule that allows the Contractor to meet the State's performance requirements. At a minimum, this shall include the following:	
IS1	3.1.2.A.1	**3.1.2.A.1** Enrollee and provider file updates to be daily;	▪ Sample Reports ▪ Daily Updated Enrollee Files Report ▪ Policies and Procedures addressing the following: ➢ Frequency of Enrollee and Provider File Updates
IS2	3.1.2.A.2	**3.1.2.A.2** Reference file updates to be at least weekly or as needed;	▪ Sample Reports

			▪ Policies and Procedures addressing the following: ➢ Frequency of Reference File Updates
IS3	3.1.2.A.3	**3.1.2.A.3** Prior authorizations and referral updates to be daily;	▪ Sample Pre-Service Request Turn-around Time Reports ▪ Sample Pre-Service Request Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Prior Authorization and Referral Updates
IS4	3.1.2.A.4	**3.1.2.A.4** Claims and encounters to be processed (entered and edited) daily;	▪ Paid, Incurred, and Pended Claims Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Claims and Encounters Processing
IS5	3.1.2.A.5	**3.1.2.A.5** Claim payments to be at a minimum biweekly except as necessary to meet the requirements in Article 7.16.5	▪ Example of Provider Remittance Inventory with receipt date ▪ Policies and Procedures addressing the following: ➢ Claims Processing
IS6	3.1.2.A.6	**3.1.2.A.6** Capitation payments to be monthly	▪ Policies and Procedures addressing the following: ➢ Capitation Payment Processing ➢ Check Register Lists
IS7	3.1.3.A	**3.1.3.A** **Regular Reporting** The Contractor's system shall provide sufficient reports to meet the requirements of this contract as well as to support the efficient and effective operation of its business functions. The required reports, including time frames and format requirements, are in Section A of the Appendices.	▪ Master Report Schedule ▪ Compliance Tracking Documents
IS8	3.1.3.B	**3.1.3.B** **Ad Hoc Reporting** The Contractor shall have the capability to support ad hoc reporting requests, at no additional cost, in addition to those listed in this contract, both from its own organization and from the State in a reasonable time frame. The time frame for submission of the report will be determined by DMAHS with input from the Contractor based on the nature of the report. DMAHS shall at its option request six (6) to eight (8) reports per year, hardcopy or electronic reports and/or file extracts. This does not preclude or prevent DMAHS from requiring, or the Contractor from	▪ Information System (IS) Data Reporting Request Form ▪ Sample of Ad Hoc Reports ▪ IS Vendor Request Form ▪ Provider Data Reporting Request Form

		providing, additional reports, at no additional cost, that are required by State or federal governmental entities or any court of competent jurisdiction.	
IS9	3.7.1.A 3.7.1.A.3	**3.7.1.A** The system shall provide data to assist in the definition and establishment of Contractor performance measurement standards, norms and service criteria. **3.7.1.A.3** It should maintain data for medical, behavioral, dental and MLTSS assessments and evaluations.	▪ Sample Performance Reports ▪ HEDIS® Reports ▪ MLTSS assessment and evaluation reports
IS10	3.7.1.A.7	**3.7.1.A.7** Reports should facilitate at a minimum monthly tracking and trending of enrollee care issues to monitor and assess Contractor and provider performance and services provided to enrollees.	▪ Policies and Procedures addressing the following: ➢ Tracking and Trending ➢ Monthly Tracking Reports such as: ➢ Quality of Care/Service ➢ Grievances ➢ Utilization of Services ➢ Access and Availability
IS11	3.8	**3.8** The MCMIS shall have a comprehensive reporting capability to support the reporting requirements of this contract and the management needs for all of the Contractor operations.	▪ Grievance Reports ▪ Pended Claims Reports ▪ Quality Reports ▪ Sample of canned reports such as: ▪ Member grievance report ▪ Monthly dashboard reports ▪ Monthly pended claims report
IS12	3.8.1.D	**3.8.1.D** The Contractor shall acquire the capability to receive and transmit data in a secure manner electronically to and from the State's data centers, which are operated by OIT. The standard data transfer software that OIT utilizes for electronic data exchange is Connect: Direct. Both mainframe and PC versions are available. A dedicated line is preferred, but at a minimum connectivity software can be used for the connection.	▪ Flowchart of Network Process ▪ Data Transfer Procedure ▪ A Screen Print of Logins ▪ Confirmation correspondence from DMAHS showing receipt of electronically submitted data
IS13	3.1.2.F	**3.1.2.F** If the Contractor uses different systems or engages in a delegated or sub-contracting arrangement for physical health, behavioral health and/or long-term services and supports, these systems shall be interoperable with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.	▪ Flowchart showing integration of data from delegated entities ▪ Demonstration of plan access to delegated services
IS14***	3.1.2.G	**3.1.2.G**	▪ Demonstration of document management for MLTSS

		The Contractor shall ensure that images of documents used by Members and providers to support Care Management processes are indexed and maintain logical relationships to certain key data such as Member identification and provider identification number.	▪ Review of MLTSS CM system
IS15**	3.1.2.I	**3.1.2.I** The Contractor's system shall be able to electronically track, store and share real-time the end- to-end data necessary to complete MLTSS Care Management processes for enrollees receiving long term services and supports including but not limited to, systems alerts for changes related to identification of potential members and the referral date of MLTSS clinical eligibility evaluation, MLTSS status, financial data, clinical eligibility status, NJ Choice assessment system assessment data, and plan of care data. See Article 9.2 for additional detail on the Member's electronic Care Management record.	▪ System documentation regarding tracking of alerts ▪ Integration of new enrollees in MLTSS system ▪ Reporting of potential MLTSS members ▪ Review of MLTSS system onsite
IS16	3.1.2.J	**3.1.2.J** The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level. If the Contractor's integrated systems include other lines of business, e.g. Medicare or commercial insurance, or Fully Integrated Dual Eligible (FIDE) SNP) or business in other states, those systems must have the capability to segregate the information by product line to allow for direct viewing of all Medicaid/NJ FamilyCare information by the State and/or its vendors.	▪ Documentation relating to capability of separating NJ specific LOBs ▪ Demonstration of electronic access to NJ CM, UM, Claims, Grievances for NJ DMAHS staff and their representatives ▪ Security documents/policies related to access to NJ LOB data
IS17**	3.1.2.K	**3.1.2.K** The Contractor's system shall include a means for the MLTSS Care Manager to ensure that home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary. This shall include either notification from providers or Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.	▪ Reports of services rendered to MLTSS members ▪ Flowchart on MLTSS reporting ▪ Demonstration of real time access to service data
IS18*	4.7.4.A	**4.7.4** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

2023 Core Medicaid Care Management Document Submission Guide – Appendix G2

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** In addition to the standards set forth in this Article, the Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description
Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Care Management Standards. Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.**

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		with the goal of improving, maintaining, or slowing the deterioration of their health status.	▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care	**Findings from the file review will be used to verify compliance. Information from the Chart**

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.	**Audit review will be used to determine the results of this element**. ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs assessment tool.	▪ **Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM8	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs and level of care. Implementation of the Enrollee's Care Plan should enhance his/her	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Care Management Flowchart Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCO must develop policies and procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement ➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care**	**Findings from the file review will be used to verify compliance. Information from the Chart**

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
			▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18c	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18d	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details.	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be used to determine the results of this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports ▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services, and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5. I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5. L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change. **4.6.5.L** Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies
CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management	▪ Policies and Procedures addressing the following: ➢ Care Management

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers and medical director, DCP&P/DCF case worker or authorized representative.	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care,	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities ➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM37	4.7.4.A	4.7.4.A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

New Jersey Annual Assessment of MCO Operations

MLTSS HCBS CM
2023 MLTSS CM Audit Submission Guide

Appendix G3

Care Management and Continuity of Care			
2023 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.6 4.1.1.F.1 9.3.3 9.3.3.A 9.3.3.B 9.3.3.C 9.3.3.D 9.3.3.E 9.3.3.F 9.6.6.E 4.1.1.E 9.6.6.F	4.6.5.D.6 If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty-five (45) calendar days of the Enrollee's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. 9.3.3 The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: 9.3.3.A	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

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		Have a mechanism for allowing a Member to request and be granted a change of provider. 9.3.3.B Notify providers of their role in providing continuity of care for their members in transition. 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services to include NF/SCNF to NF/SCNF Transfer(s); 1.Care Manager shall make telephonic contact with the receiving facility within five (5) business days of placement following a members transfer, 2.Care Manager shall complete a Face-to-Face visit and update the member's plan of care within forty-five (45) business days of placement. 9.3.3.D Work with the provider that is no longer willing or able to provide services to a Member to cooperate with the Member's Care Manager to facilitate a seamless transition to another provider and continue to provide services to the Member until the Member has been transitioned to the other provider. 9.3.3.E Have a mechanism for information exchange between providers in accordance with termination timeframes outlined in section 4.9.3; and 9.3.3.F	

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		Have a mechanism for ensuring confidentiality as specified in Article 7.38. 9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

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Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Enrollees the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. New enrollees who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1. B MLTSS Care Management Standards General MLTSS Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-neutral manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1. D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

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CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long-term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow-up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health, and long-term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.
CM30	9.5.1.I 9.5.1. J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers, and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers, and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2. B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or	▪ Care Management job descriptions used in recruitment. ▪ Organization Chart with CM names ▪ CM resumes

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		3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members. 2. Caseload management and casework practices. 3. Human services principles for determining eligibility for benefits and services. 4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A Training of Care Management Staff The Contractor shall develop standardized initial and ongoing quarterly and annual training and education which includes the following components: 1.Training curriculum including topic, goals of training, length, format, materials, prerequisites, and competency standards for each training area 2.Training records for each employee documenting trainings completed, date, competency and remediation actions 3.Quality Assurance program to identify inter/intra-rater reliability and core standards 4.Continuous Quality Assurance monitoring and standards to ensure standards are being met 5.Remediation training plan for employees who do not meet the standards. 9.5.4.A	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

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		A. Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request. 9.5.4.B All MLTSS Care Managers must be NJ Choice certified and able to conduct the NJ Choice Assessment System for initial and re-evaluations. The Contractor shall submit to DoAS a complete listing of Care Management Training and Education activities scheduled for each calendar month. Reports are due by the 20th day of the month prior to the scheduled training month. The listing shall include the training title, description, instructor, date and time, target audience, and location or mode of delivery.	
CM34	9.5.5. J	9.5.5.J J. Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

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		4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance. 5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2. A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4. A	4.7.4. A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested and, in the time, frames specified, generally within thirty (30) days or	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period.

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		as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
CM38	9.4.1.A.4 9.5.1. E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. MLTSS members shall have no more than one change in their assigned primary Care Manager within a calendar year unless the change is due to member relocation, change in Care Manager employment (i.e. termination or leave), requested by member, or any other reason approved by DMAHS. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy