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

CORE MEDICAID and MLTSS QUALITY TECHNICAL REPORT

April 2016–December 2017

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EXECUTIVE SUMMARY

Background

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

The MCOs Aetna Better Health of New Jersey (ABHNJ), Amerigroup New Jersey, Inc. (AGNJ), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and WellCare Health Plans of New Jersey, Inc. (WCHP) participated in the NJ FamilyCare Managed Care Program in 2016 and 2017. Enrollment in ABHNJ, AGNJ, HNJH, UHCCP, and WCHP for Core Medicaid and Managed Long Term Services and Supports (MLTSS) was 1,677,902 as of 12/31/2016 and 1,650,804 as of 12/31/2017.

External quality review (EQR) activities conducted during April 2016–December 2017 included annual assessment of MCO operations, performance measure (PM) validation, quality improvement projects (QIPs), Core Medicaid encounter data validation, focused quality studies, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys, Core Medicaid care management (CM) audits, and MLTSS CM Audits.

State Initiatives

The New Jersey Medicaid Accountable Care Demonstration Project

In August 2011, Governor Christie signed into law (NJ P.L. 2011, Chap 114) requiring DMAHS to establish a three year Medicaid Accountable Care Organization (ACO) demonstration project designed to improve health outcomes, quality and access to care through regional collaboration, and shared accountability while reducing costs. The NJ Medicaid ACO demonstration provides Medicaid an opportunity to explore innovative system re-design including; testing the ACO as an alternative to managed care; rethinking how care management and care coordination should be delivered to high risk, high cost utilizers; stretching the role of Medicaid beyond just medical services but to integrate social services as well; and finally, testing payment reform in terms of pay for performance metrics and incentives. DMAHS launched the demonstration in July, 2015 and it will conclude in June, 2018. An evaluation report from year 1 of the Demonstration is expected to be published later this year.

Value-Based Purchasing

The Division has taken a thoughtful approach in selecting our value-based purchasing. The Division applied and was chosen to participate in the Value-Based Purchasing Innovation Accelerator Program (IAP), which provides technical support around designing, developing and implementing value-based payment approaches in managed care. For the IAP, the focus is developing a financial simulation for a pediatric asthma bundled payment. The financial simulation will help us to determine both financial and resource feasibility in developing, administering and monitoring a bundled payment model. In addition, the Division is currently developing a maternity episode of care as part of a larger maternal health policy initiative around improving maternal health and birth outcomes.

Health Information Technology

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

In February 2015, DMAHS awarded the contract for the Replacement MMIS to Molina Medicaid Solutions. The Design, Development, and Implementation phase began in mid-2015, with a planned late 2018 implementation timeline. Currently, Phase 3 (Requirements Analysis and Design) of the System Development Life Cycle is nearing completion, and tasks and activities for Phase 4 (Development and Test) have already begun. Multiple phases will run concurrently in this agile deployment. The goal of the project is to provide DMAHS with the system infrastructure, technical capabilities and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation.

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

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

Medicaid Information Technology Architecture Project and Master Client Index Project

In addition to the Replacement MMIS project, DMAHS has established an enterprise Master Client Index (MCI) linking the legacy NJ Medicaid Management Information Systems (MMIS) with the NJ Department of Health (DOH) Immunization Registry and NJ DOH Blood Lead Registry. The MCI will also be integrated with the new Replacement MMIS project for MMIS identity management and to meet RMMIS bi-directional data exchange requirements with NJ State Health Registries.

Medicaid Innovation Accelerator Program

CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting the state's efforts to accelerate new payment and service delivery reforms.

The main goal of the initiative is to enhance CMS's wide ranging efforts to improve care by supporting system-wide payment and delivery system reform innovation. CMS is using the IAP to work closely with states, consumers, and health providers on critical issues through technical assistance, tool development and cross-state and national learning opportunities.

Community Based Care Management Demonstration

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

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

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

NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), the Human Services Research Institute (HSRI), state Medicaid, and aging and disability agencies. New Jersey voluntarily participates in this extensive, confidential, face to face consumer survey which focuses on people with physical disabilities and on older adults. The purpose of the survey is to procure feedback directly from service recipients regarding service satisfaction and quality of life issues. The NCI-AD survey is important to NJ because data gleaned from survey participants can be measured, tracked, and applied to future State initiatives. The MACCs (Medical Assistance Customers Centers), MLTSS Steering Committee, PACE, NJ Hospital Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy. New Jersey first partnered with NCI-AD in 2015 and surveyed over seven hundred people. In 2016, over nine hundred residents of the State were surveyed, including Managed Long Term Services and Supports (MLTSS) nursing facility (NF) and MLTSS home and community based residents, members in the Program of All-inclusive Care for the Elderly, and those in the Older Americans Act. Participants in the survey were individuals who have been receiving long term services and supports for a minimum of six months. Recipients were assessed regarding the outcomes of services they received with the goal of assisting the State to improve the quality of services and supports that are provided to NJ residents. Surveyors received annual training regarding the survey process inclusive of creating a positive survey experience, interview techniques for older adults and people with disabilities, the use of proxy assistance, and mandatory reporting requirements. The 2016 survey contained approximately ninety questions that included the domains of: home, relationships, service satisfaction, direct care workers, daily activities, physical environment, safety/security/privacy, community, everyday living, health and wellness, healthcare, future planning, and independence. New Jersey also created eleven questions unique to the State that addressed specific concerns relevant to NJ and its residents. These included the categories of member needs, in home assistance, home delivered meals, and individualized plans of care. At the end of the survey interviewers received feedback and any unmet needs that the individual identified and wished to have addressed were noted and appropriate follow-up was performed. As participating states measure and track their own performance, NJ State-specific performance reports regarding core indicators are available for year over year comparison along with additional information regarding the NCI-AD survey process on the NCI-AD website, www.nci-ad.org .

Annual Assessment of MCO Operations

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

2016 Annual Assessment of MCO Operations

In 2016, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2016 compliance scores from the annual assessment ranged from 74% to 96%. ABHNJ's compliance score increased 12 percentage points from 62% from their initial review in 2015 to 74% in 2016. WCHP's compliance score increased 15 percentage points to 87% in 2016. The review categories of Satisfaction and Enrollee Rights and Responsibilities showed MCO average scores of 100% compliance. The review category with the lowest MCO average score was Efforts to Reduce Healthcare Disparities at 45% average in 2016, an increase of 32 percentage point from 13% in 2015. Compliance score averages stayed the same as or increased from 2015 to 2016 for all standards, except for the Utilization Management compliance score average, which decreased 5 percentage points from 93% in 2015 to 88% in 2016.

2017 Annual Assessment of MCO Operations

In 2017, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2017 compliance scores from the annual assessment ranged from 87% to 98%. ABHNJ's compliance score increased 13 percentage points from 74% to 87% in 2017. WCHP's compliance score increased 11 percentage points to 98% in 2017. The review categories of Committee Structure and Enrollee Rights and Responsibilities showed MCO average scores of 100% compliance. The review category with the lowest MCO average score was Efforts to Reduce Healthcare Disparities at 76% average in 2017, an increase of 31 percentage point from 45% in 2016. Compliance score averages stayed the same

as or increased from 2016 to 2017 for all standards, except for the Satisfaction and Administration and Operations compliance score averages, which decreased 5 and 7 percentage points, respectively, from 2016 to 2017, but remained above 90%.

Performance Measures

2016 and 2017 Core Medicaid Performance Measures

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

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. As a part of the assessment, IPRO also compared the MCOs' reported HEDIS results to national Medicaid 25th and 50th percentiles from NCQA's *Quality Compass*, a widely accepted source of Medicaid benchmark data.

2016 Core Medicaid Performance Measure Strengths

Overall, most measures remained constant from measurement year (MY) 2014 to MY 2015 (< 5 percentage point change) for the NJ Medicaid average. Significant improvements (≥ 5 percentage point increase) in performance from MY 2014 to MY 2015 were noted for Comprehensive Diabetes Care (Medical Attention for Nephropathy), BMI Assessment for Children/Adolescents (3–11 Years, 12–17 Years, and Total), Follow-up After Hospitalization for Mental Illness (30-Day Follow-up), and Adult BMI Assessment.

2017 Core Medicaid Performance Measure Strengths

Overall, the NJ Medicaid average rates remained relatively constant between MY 2015 and MY 2016 (with a < 5 percentage point change year over year) for most measures, although significant improvements in rates were reported for the Comprehensive Diabetes Care measure, for which rates increased by 6.79 percentage points for HbA1c Poor Control (> 9.0%), 7.17 percentage points for HbA1c Control (< 8.0%), and 6.80 percentage points for Eye Exam.

2016 and 2017 New Jersey State-Specific Performance Measures

As more patients with disabilities and chronic conditions transition to managed care from Fee-for-Service (FFS), three performance measures were developed by IPRO, in conjunction with DMAHS. These measures were derived from existing HEDIS performance measures to help monitor care for vulnerable populations, and can be used to identify areas in need of improvement for reducing disparities in care. These measures are: Adults' Access to Preventive/Ambulatory Health Services (AAP), Children and Adolescents' Access to Primary Care Practitioners (CAP), and Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit). Each measure is reportable by the total Medicaid population and by three subpopulations: Medicaid/Medicare Dual-Eligibles, Medicaid Disabled, and Other Low Income.

2016 and 2017 MLTSS Performance Measure Validation

During July 1, 2015–June 30, 2016, IPRO worked closely with NJ MLTSS staff and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications were developed for the following PMs: #4: Timeliness of Nursing Facility Level of Care Assessment by MCO; #20: Total Number of MLTSS Members Receiving MLTSS Services; #21: MLTSS Members Transitioned from NF to Community; #22: New NF Living Arrangement for MLTSS Members; #23: NF to HCBS Transitions who Returned to NF within 90 Days: #24: MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days; #25: MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less; #26 and #27: Acute Inpatient Utilization by MLTSS Members; #28: Readmissions of MLTSS HCBS Members to Hospital within 30 Days; #29: Readmissions of MLTSS NF Members to Hospital within 30 Days; #30 and #31: ER Utilization by MLTSS Members; #33, #34 and #41: MLTSS Services Used by MLTSS HCBS Members; #35 and #36: Follow-Up After Mental Health Hospitalization for HCBS MLTSS Members; #37 and #38: Follow-Up After Mental Health Hospitalization for NF Members; and #39 and #40: MLTSS Members with Select Behavioral Heath Diagnoses.

The annual (MY July 1, 2015–June 30,2016) statewide rate for Timeliness of Nursing Facility Level of Care Assessment was 91%; for Total Number of MLTSS Members Receiving MLTSS Services was 81%; for MLTSS Members Transitioned from NF to Community was 2%; for New NF Living Arrangement for MLTSS Members was 33%; for NF to HCBS Transitions who Returned to NF within 90 Days was 8%; and for MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days was 92% (by complement, MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less rate was 8%). Statewide, Acute Inpatient Utilization by MLTSS Members rate was 48 events per 1,000 member months (MM) for HCBS members and 38 events per 1,000 MM for NF members. The statewide rates for Readmissions of MLTSS HCBS and NF Members to Hospital within 30 Days were 16% for HCBS members and 15% for NF members. Statewide, ER Utilization by MLTSS Members rate was 74 events per 1,000 MM for HCBS members and 34 events per 1,000 MM for NF members. Measures #33, 34 and 41 evaluate the percent of HCBS members receiving only personal care assistant (PCA), only medical day, or both PCA and medical day services; in aggregate, a statewide rate of 26% of members fell into one of these three categories; Only one MCO had 30 or more cases in the denominator for Follow-up After Mental Health Hospitalization for HCBS MLTSS Members and no MCO had more than 30 cases in the denominator for Follow-up After Mental Health Hospitalization for NF MLTSS Members. Statewide rates for 30-day follow up were 64% for HCBS members and 63% for NF members. The statewide rate for MLTSS Members with Select Behavioral Heath Diagnoses was 27% for HCBS members and 46% for NF members.

IPRO worked with the State and the MCOs to make modifications as necessary to the specifications for MY 2017/2018. These specifications were in for the period beginning July 1, 2017. Four new PMs were added for the MY 2017/2018 period: #42: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for HCBS MLTSS Members; #43: Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependences for NF MLTSS Members; #44: Follow-up After Emergency Department Visit for Mental Illness for HCBS MLTSS Members; and #45: Follow-up After Emergency Department Visit for Mental Illness for NF MLTSS Members.

2016 and 2017 MLTSS Performance Measure 13

Performance Measure 13 evaluates delivery of MLTSS services to members compared with services identified in the Plan of Care (POC). This measure ensures HCBS MLTSS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. In 2016, IPRO evaluated the feasibility of producing PM 13 using administrative data rather than CM record review. The administrative methodology used authorizations data provided by each MCO as a proxy for the POC. IPRO obtained claims and authorizations data from each MCO, and conducted a preliminary comparison of claims to authorizations, whereby services in the authorization file were matched with services in the claims file to assess if the services were delivered as planned. IPRO also reviewed CM records from each MCO to assess whether authorizations data were a reasonable representation of the information contained in the POC. The results of the preliminary claims/authorizations comparison and findings from the CM record review demonstrated that the administrative methodology was not a viable substitute for a comparison of claims against CM records. It was concluded that the assessment of PM 13 requires a CM record review methodology, where POCs are compared to claims to determine if services were delivered appropriately.

In July 1, 2015–June 30, 2016, IPRO undertook an analysis POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (blackout periods). A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and blackout period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2015 and June 30, 2016.

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

The overall compliance rate for PM 13 was 25.3%. HNJH had the lowest compliance rate at 18.4%. The highest compliance rate was achieved by ABHNJ at 34.4%. However, it should be noted that ABHNJ had the lowest sample size of all the MCOs due to the high number of exclusions. Across all plans, the most common MLTSS service was PCA/Home Based Supportive Care; of the 248 members who had PCA/Home Based Supportive Care services planned, 68 (27.4%) received, on average, 95% or more of the planned amount. Of the MLTSS services listed, Assisted Living was associated with the highest proportion of members reaching the 95% average threshold; of the 75 members who had Assisted Living services planned, 53 (70.7%) received on average at least 95% of the planned amount.

In 2017, IPRO undertook evaluation of PM 13 for the July 2016–June 2017 time period. MCOs were given a six-month lag period to submit claims for the measure. POC information was abstracted during the HCBS Care Management Audit. MCOs submitted blackout periods for members who were not receiving services due to member choice or member absence from the home. The same methodology was followed for this time period as was followed in the prior report. Results of the analysis will be provided to the State in 2018.

Core Medicaid/MLTSS Quality Improvement Projects

For April 2016–December 2017, the QTR reflects IPRO's evaluation of the June and September 2016 and 2017 QIP report submissions. IPRO's QIP 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. The four QIP topics were related to the identification and management of obesity in adolescents, reduction of preterm births, prevention of falls for the MLTSS population, and the improvement of developmental screening and referral rates for early intervention for children aged 0-3 years.

Core Medicaid Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State encounter data unit and the EQRO. It includes both a baseline evaluation and ongoing monitoring of submission patterns. 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. On June 20, 2016, IPRO requested that DMAHS complete an information system capabilities assessment (ISCA) by July 30, 2016. The ISCA tool was developed by IPRO and based on CMS' ISCA tool developed on 5/1/2002. The review of the State's requirements and processes provided IPRO with a baseline assessment of the State's EDV process.

As a part of CMS's EDV protocol and first activity, IPRO reviewed DMAHS's Encounter Data Monitoring Unit (EDMU) requirements for collection and submission of encounter data. The second activity of CMS's EDV protocol is the review of the MCO's capability to produce accurate and complete encounter data. On November 17, 2016, IPRO emailed the MCOs advising that they are required to complete the ISCA tool by December 30, 2016. IPRO analyzed information from the MCO ISCA tools and conducted EDV onsite visits with the MCOs during January and February 2017.

Focused Quality Studies

2016 Focused Study #1: Developmental Screening, Medicaid Managed Care Enrollees

IPRO conducted one clinical focused study that was completed in 2016 on developmental screening and associated practice patterns among clinicians caring for NJ MMC-enrolled children between birth to 3 years old in the general population (GP) as well as children in the Aged, Blind and Disabled (ABD) and in the Division of Child Protection and Permanency (DCP&P) eligibility populations. The study provided an assessment of developmental surveillance, formal developmental screening, follow-up actions for any identified surveillance concerns or abnormal developmental screens including the involvement of early intervention (EI) services, and MCO interventions in care or case management for children identified to be at risk for developmental delay (including coordination with EI). Medical records were requested from primary care providers associated with the latest identified well-child visit during the measurement period, July 1, 2014 through June 30, 2015.

Identification of developmental delays is necessary, but not sufficient, to ensure that appropriate referrals are made, services are obtained, and that primary care providers know the outcomes of referrals. Ultimately, improved compliance with clinical practice guidelines for standardized global developmental screening, along with improved communication to ensure follow-up, would be expected to improve early detection. It would also be expected to improve timely intervention for children who are noted to have developmental delays; thus, decreasing the life-long impact of developmental delays that affect children and their families.

2016 Focused Study #2: Developmental Screening, Medicaid Managed Care Enrollees

Comprehensive well-child care includes surveillance and screening for developmental disorders. Monitoring for developmental disorders is especially important for children enrolled in MMC, who have a nearly two-fold higher prevalence of developmental delay compared to children who are privately insured. There is evidence in published reports that developmental delays are often not identified in a timely manner, with some children not identified with developmental problems until school entry, past the point at which early intervention is most effective. Formal developmental screening facilitates the timely identification of risk for developmental delay and referral for Early Intervention (EI) services, which is associated with improved long term outcomes.

The scope of Study #2 encompasses MCO care management and case management for the general population for children who are either potentially in need of EI services or are receiving EI services, as well as children involved with lead case management. The need for EI services is established when a child is not receiving, but referred to EI services following a confirmation of presumptive eligibility, risk of developmental delay, or abnormal indicator identified by developmental surveillance; the potential need of EI is when a child has not been receiving (or referred to) EI services despite an indicator (at least one triggering diagnosis that presumes EI eligibility, chronic condition associated with risk of developmental delay, or documentation of a toxic environmental exposure). Risk factors for lack of screening and referral, particularly for EI services, are assessed by Study #2. Furthermore, this study assesses the policies, processes, and procedures undertaken by MCOs to identify candidates for EI or members receiving EI services, and the roles played by care managers, case managers, and lead case managers in coordinating services for members receiving, or identified as in need of, EI services.

The methodology for Study #2 involves: MCO care management, case management, and lead case management record abstraction; administrative data, including rosters, member demographics, encounters/claims, medical and behavioral diagnoses which trigger presumptive eligibility, chronic conditions that confer risk for developmental delay, and lead screening; and a survey of MCOs on their policies and procedures to identify candidates for EI and on how administrative data is used for EI services. MCO-generated rosters of members enrolled in case management, care management and lead case management are integrated into a request for each MCO to provide internal records on care management, case management, and lead case management for eligible members, from which the record-based information is abstracted and merged with the other data sources. In addition to the record review, EI services, presumptive diagnoses and enrollment in care management, case management and lead case management for the general population, using MCO encounter data and EI claims data, will be described for population-level analyses.

CAHPS 2016 Survey

IPRO subcontracted with a certified survey vendor to field the CAHPS surveys for the Medicaid population. Five Medicaid adult surveys were fielded; one for each of the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP), Five Medicaid child surveys were fielded; one for each of the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) which combines Medicaid and Children's Health Insurance Program (CHIP) enrollment for each MCO. In addition, one statewide CHIP-only survey was conducted. All of the members surveyed required continuous enrollment from January 1, 2016 through June 30, 2016, 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.

CAHPS 2017 Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2016 through December 31, 2016, 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.

Care Management Audits

Core Medicaid Care Management Audits

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

The 2016 Core Medicaid Care Management Audit rates across all MCOs, populations, and categories ranged from 65% to 100%. Scores for Continuity of Care and Coordination of Services were above 90% for all five MCOs for all (GP, DDD, DCP&P) populations in 2016. Scores for Identification for the DDD and DCP&P populations were all above 90% across all five MCOs in 2016.

Five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD, DCP&P, and GP) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 75 scores. Out of the five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) across the General, DDD and DCP&P populations and across five plans that were comparable to 2015 (75 in total), forty-one (41) scored higher, twenty-three (23) remained the same, and eleven (11) scored lower in 2016.

2016 MLTSS HCBS Care Management Audits

The purpose of the MLTSS HCBS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to members who met MLTSS eligibility requirements 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 HCBS services by residing in the community or Community Alternative Residential Settings (CARS) within the review period from 7/1/2015 through 6/30/2016. The results from the previous review period 7/1/2014–6/30/2015 were included in the QTR for 2015.This QTR includes the new results from 7/1/2015–6/30/2016.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial Plan of Care established within 30 calendar days of enrollment into MLTSS HCBS; #9 – Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's Plan of Care is amended based on change of member condition; #10 – Plans of Care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of Care developed using "person-centered principles"; #12 – MLTSS HCBS Plans of Care that contain a Back-up Plan if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated January 2016. MLTSS PMs #9, #9a, and #16 were added for the review period of 7/1/2015–6/30/16. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. A random sample for each MCO was generated to meet the minimum of 100 records needed for each MCO which included newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/15 and 1/1/16 (Group C) and existing MMC members enrolled in MLTSS between 7/1/15 and 1/1/16 (Group D). If the MCO did not have 100 files, the entire universe was selected for review.

Across all plans, the NJ weighted average for the 7/1/2015–6/30/2016 audit results for both Groups C and D ranged from 44.6% for PM #11 – Plans of Care developed using "person-centered principles" to 97.6% for PM #10 -Plans of Care are aligned with member needs based on the results of the NJ Choice Assessment.

2017 MLTSS HCBS Care Management Audits

The purpose of the annual MLTSS HCBS CM audit was to continue to evaluate the effectiveness of the contractually required MLTSS CM programs of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or CARS within the review period from 7/1/2016 through 6/30/2017. The results from the previous review period (7/1/2015–6/30/2016) were compared to the 2017 audit, which includes the new results from 7/1/2016–6/30/2017.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 30 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated July 2016. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/16 and 1/1/17(Group C) and existing MMC members enrolled in MLTSS between 7/1/16 and 1/1/17 (Group D), the 2017 audit included a new subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2016) and continuously enrolled with the MCO in MLTSS through 6/30/17. A minimum of 100 files were to be reviewed and abstracted across all three groups. An oversample was selected for the MCO to replace any excluded files.

Across all plans, the total NJ weighted average for the 7/1/2016–6/30/2017 audit results for Groups C, D and E ranged from 37.7% for PM #9a -Member's plan of care is amended based on change of member condition to 84.0% for PM #10 - Plans of care are aligned with member needs based on the results of the NJ Choice Assessment.

2016 MLTSS Nursing Facility Care Management Audits

The purpose of the MLTSS NF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2015. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in an NF or Special Care Nursing Facility (SCNF) for at least six consecutive months within the review period from 7/1/2015 through 6/30/2016.

IPRO identified the specific populations using eligibility data using capitation codes to identify MLTSS HCBS and NF/SCNF enrollment. A random sample for each MCO was generated to meet the minimum of 100 records needed for each MCO which included MLTSS members permanently residing in an NF/SCNF between 7/1/2015 through 6/30/ 2016 (Group 1), MLTSS members residing in an NF/SCNF for at least six consecutive months between 7/1/2015 and 6/30/2016 and

transitioned to HCBS for at least one month during the review period (Group 2), MLTSS members residing in HCBS for at least one month and transitioned to an NF/SCNF for at least six consecutive months during the review period (and still residing in the NF/SCNF) at the end of the review period (Group 3), and MLTSS members residing in HCBS for at least one month, transitioned to an NF/SCNF for at least six consecutive months, and transitioned back to HCBS for at least one month during the review period (Group 4). Members residing in an NF/SCNF less than six consecutive months at any time between 7/1/2015 and 6/30/2016 were excluded from the study. If the MCO did not have 100 files, the entire universe was selected for review.

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

Four MCOs had members that fell in the category of HCBS Members Transferred to an NF/SCNF. There were no review elements that scored above 85% across these four MCOs. Two of the four MCOs scored above 85% for having a New Jersey Choice Assessment Completed to Reassess a Member for Transfer to an NF/SCNF. It was noted that one MCO scored above 85% in 5 of the 14 review elements, one MCO scored above 85% in 2 of the 14 review elements and one MCO in 1 of the 14 review elements; however, caution should be taken during the interpretation of these results due to the low number of care management records reviewed for some of the elements. All four MCOs have an opportunity for improvement in IDT meeting attendance pertaining to member transfer to an NF/SCNF, amending the plans of care as appropriate, and including a completed PASRR Level I or Level II (if applicable) prior to transfer to an NF/SCNF on file.

Conclusion and MCO Recommendations

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

CHAPTER 1 – INTRODUCTION

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

DMAHS has contracted with IPRO to serve as its EQRO. As a part of this contract, IPRO assesses MCO operations and performance on key activities and provides recommendations on how these activities can improve the timeliness, quality, and access to healthcare services for enrollees. This report is the result of IPRO's assessment and review of MCO activities for the period from April 2016 through December 2017.

Background

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. As of December 2017, there were approximately 1,650,804 individuals enrolled in MMC and the number decreased from 1,677,902 in December 2016 (**Table 1**). Of the 1,650,804 individuals enrolled in MMC, 39,973 were receiving MLTSS services as of December 2017. Approximately 90% of managed care eligible beneficiaries receive services through the managed care program.

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

In 2011, NJ applied for a five-year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver encompassing nearly all services and eligible populations served under a single authority. In October 2012, CMS approved NJ's request for the new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver." Under this demonstration, NJ will operate a statewide health reform effort that will expand existing managed care programs to include MLTSS and expand home and community-based services (HCBS) to some populations. The New Jersey Comprehensive 1115 Medicaid Waiver was approved in October 2012. Implementation of the MLTSS HCBS and NF services for new MLTSS members began in July 2014. MLTSS enrollment was approximately 39,973 as of December 2017 (**Table 1**).

Five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in the NJ FamilyCare Managed Care Program for Medicaid and MLTSS in April 2016–December 2017. **Table 1** presents respective enrollment figures in December 2015, December 2016, and December 2017.

Table 1: 2015–2017 MCO Enrollment

MCO	Acronym	Medicaid Enrollment			MLTSS-Eligible Enrollment[1]		
		December 2015	December 2016	December 2017	December 2015	December 2016	December 2017
Aetna Better Health of New Jersey	ABHNJ	18,657	29,254	40,264	402	1,068	2,212
Amerigroup New Jersey, Inc.	AGNJ	206,392	208,326	192,745	3,582	5,602	6,999
Horizon NJ Health	HNJH	841,027	888,177	871,766	11,200	14,687	16,822
UnitedHealthcare Community Plan	UHCCP	482,316	490,792	481,836	4,847	6,512	7,597
WellCare Health Plans of New Jersey, Inc.	WCHP	55,920	61,353	64,193	2,290	4,758	6,343
Total		**1,604,312**	**1,677,902**	**1,650,804**	**22,321**	**32,627**	**39,973**

[1]Managed Long Term Services and Supports (MLTSS) members are included in the December 2015–2017 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 2015, December 2016, and December 2017 in relation to the entire NJ Medicaid population.

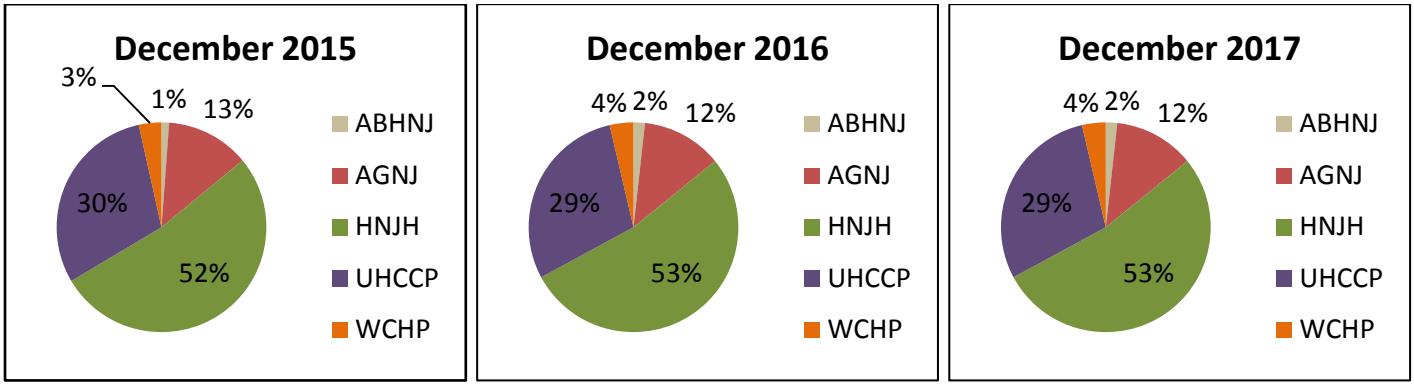

Figure 1: 2015–2017 Medicaid Enrollment Percentages by MCO. Enrollment in total Medicaid for each MCO reported in **Table 1** as of December 2015 (left panel), December 2016 (middle panel), and December 2017 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (beige); AGNJ: Amerigroup New Jersey, Inc. (red); HNJH: Horizon NJ Health (green); UHCCP: UnitedHealthcare Community Plan (purple); WCHP: WellCare Health Plans of New Jersey, Inc. (orange). Percentages may not add to 100% due to rounding.

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

Table 2: April 2016–December 2017 EQR Activities by MCO

MCO	EQR Activity[1]								
	Annual Assessment of MCO Operations	PMs	Core Medicaid/ MLTSS QIPs	Medicaid EDV	Focused Quality Studies	CAHPS Surveys	Core Medicaid CM Audits	MLTSS HCBS CM Audits	MLTSS NF CM Audits
ABHNJ	√√	√√	√√	√	√√	√√	√	√√	√
AGNJ	√√	√√	√√	√	√√	√√	√	√√	√
HNJH	√√	√√	√√	√	√√	√√	√	√√	√
UHCCP	√√	√√	√√	√	√√	√√	√	√√	√
WCHP	√√	√√	√√	√	√√	√√	√	√√	√

[1] The number of check marks indicates the number of activities for each particular type of activity included in this QTR for April 2016—December 2017.

EQR: external quality review; MCO: managed care organization; PM: performance measure; QIP: quality improvement project; EDV: encounter data validation; CAHPS: Consumer Assessment of Healthcare Providers and Systems; CM: care management; HCBS: home and community based services.

Purpose and Objectives

The purpose of this QTR is to: 1) discuss the results of the quality assessments performed during April 2016–December 2017 in accordance with the BBA [Subpart E, 42 CFR, Section 438.364], 2) review the strengths and weaknesses of each MCO, 3) provide recommendations for performance improvement, and 4) establish a foundation for enhancing the quality-of-care services provided to publicly funded programs in NJ. This report provides comprehensive insight about the performance of the State's MCOs on key indicators of healthcare quality for NJ FamilyCare Managed Care enrollees.

External Quality Review Activities

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

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

Table 3: Mandatory EQR-Related Activities

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

In addition, IPRO completed one clinical focused study, and fielded 2016 and 2017 CAHPS surveys for the Medicaid population. IPRO also completed CM audits to evaluate the effectiveness of the MCOs' CM programs; two for the MLTSS CM program and one for the Core Medicaid CM program were completed in April 2016–December 2017. The first MLTSS audit included a focused review of MLTSS CM PMs for members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Settings (CARS) within the review period from 7/1/2015 through 6/30/2016. The second MLTSS audit included a new subgroup (subgroup E, members in MLTSS with the MCO prior to the review period) and covered a review period from 7/1/2016 through 6/30/2017. The Core Medicaid CM audit for the review period 1/1/2016–12/31/2016 included a review of CM for the GP, in addition to the DDD and the DCP&P populations.

MCO Strength and Weakness Evaluation

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

Strengths

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

Weaknesses

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

Components of Care: Quality, Access and Timeliness

IPRO used 2016 EQR activities to create a qualitative statement about the assessments contained within this report with respect to quality, access, and timeliness. IPRO defines these elements as follows:

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

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

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

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

CHAPTER 2 – STATE INITIATIVES

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

The New Jersey Medicaid Accountable Care Demonstration Project

In August 2011, Governor Christie signed into law (NJ P.L. 2011, Chap 114) requiring DMAHS to establish a three year Medicaid Accountable Care Organization (ACO) demonstration project designed to improve health outcomes, quality and access to care through regional collaboration, and shared accountability while reducing costs. The NJ Medicaid ACO demonstration provides Medicaid an opportunity to explore innovative system re-design including; testing the ACO as an alternative to managed care; rethinking how care management and care coordination should be delivered to high risk, high cost utilizers; stretching the role of Medicaid beyond just medical services but to integrate social services as well; and finally, testing payment reform in terms of pay for performance metrics and incentives. DMAHS launched the demonstration in July, 2015 and it will conclude in June, 2018. An evaluation report from year 1 of the Demonstration is expected to be published later this year.

Value-Based Purchasing

The Division has taken a thoughtful approach in selecting our value-based purchasing. The Division applied and was chosen to participate in the Value-Based Purchasing Innovation Accelerator Program (IAP), which provides technical support around designing, developing and implementing value-based payment approaches in managed care. For the IAP, the focus is developing a financial simulation for a pediatric asthma bundled payment. The financial simulation will help us to determine both financial and resource feasibility in developing, administering and monitoring a bundled payment model. In addition, the Division is currently developing a maternity episode of care as part of a larger maternal health policy initiative around improving maternal health and birth outcomes.

Health Information Technology

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

In February 2015, DMAHS awarded the contract for the Replacement MMIS to Molina Medicaid Solutions. The Design, Development, and Implementation phase began in mid-2015, with a planned late 2018 implementation timeline. Currently, Phase 3 (Requirements Analysis and Design) of the System Development Life Cycle is nearing completion, and tasks and activities for Phase 4 (Development and Test) have already begun. Multiple phases will run concurrently in this agile deployment. The goal of the project is to provide DMAHS with the system infrastructure, technical capabilities and management tools to effectively manage the State Medicaid enterprise programs in an era of dynamic health system transformation.

The new system, referred to as the Replacement MMIS, will help ensure that members receive quality, coordinated and person-centered health services, that programs are effectively administered with the help of decision support tools, and

that fraud, waste and abuse are prevented, detected and addressed. The Replacement MMIS will enable NJ to achieve program goals that are critically intertwined with health information technology and electronic exchange of data to improve health outcomes and control program costs.

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

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

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

Anticipated Benefits

The new capabilities will allow DMAHS to:

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

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

Medicaid Information Technology Architecture Project and Master Client Index Project

In addition to the Replacement MMIS project, DMAHS has established an enterprise Master Client Index (MCI) linking the legacy NJ Medicaid Management Information Systems (MMIS) with the NJ Department of Health (DOH)

Immunization Registry and NJ DOH Blood Lead Registry. The MCI will also be integrated with the new Replacement MMIS project for MMIS identity management and to meet RMMIS bi-directional data exchange requirements with NJ State Health Registries.

The MCI is the foundation for accurate data exchange between NJ Medicaid and its partner agencies. The MCI provides the identity management necessary to associate data that resides in Medicaid, Immunization and Blood Lead Screening databases for the same person where the person demographics lack 100% consistency with regard to format and content. The MCI is used to cross reference client identifiers across each participating information system to uniquely identify each client, perform global searches and matching, consolidate duplicate client records, and create complete views of client information and share data easily across multiple facilities and information systems. DMAHS has envisioned that these initiatives will facilitate the flow of enrollee-centered health information to improve quality, patient safety and cost-effectiveness of health programs.

Anticipated Benefits from Use of Available and Evolving Health Information Technology

Health Information Exchange (HIE) has been ongoing between DMAHS and NJ DOH for blood lead screening information for over 10 years through bi-annual data matching. Through this process, DMAHS has been able to identify children with elevated blood lead levels or children who have not received a blood lead screening, and to share this information with contracted MCOs so that necessary follow-up is initiated. Efforts are underway to make the data exchange more automated, accurate and close to real-time. The process is expected to be completed with the rollout of the new Medicaid Management Information System (MMIS). The new MMIS will deploy MedCompass as a solution for blood lead screening case management. MedCompass case and utilization management functions are being integrated with the new NJ MMIS. The MMIS will utilize the MCI capabilities to cross reference client identifiers across the currently disparate Medicaid MMIS and DOH State Lead and Immunization Registries. The MCI will provide a real time feed of Medicaid children Lead Registry IDs to the new MMIS the moment any new information is received from the Lead Registry for a Medicaid child. The list of Lead Registry IDs compiled from the MCI will be utilized by the MMIS to obtain Lead screening detail from the DOH Lead Registry system for each associated Medicaid child. Thus, NJ Medicaid will be able to accurately receive and store data from the DOH Blood Lead Registry for every Medicaid child and provide these data to the NJ MMIS and MedCompass by means of frequently recurring feeds. This new initiative will improve the sharing of critical Blood Lead readings between the DOH Lead Registry and DMAHS from the current 6 months elapsed time to mere days, which will significantly improve the quality and timeliness of lead case management.

The MCI project is key to this HIE initiative and will facilitate other efforts related to the Health Information Technology for Economic and Clinical Health(HITECH) Act and the collection of quality measures required by Children Health Insurance Program Reauthorization Act (CHIPRA). It is anticipated that as the information infrastructure matures, the ability to provide real time patient information at the point of care to improve quality and safety will also be vastly improved. The eventual measurement and standardization of quality indicators will also help assess program performance, increase transparency, provide valuable information to providers on their performance on key areas and encourage adherence to evidence-based guidelines.

Medicaid Innovation Accelerator Program

CMS launched the Medicaid Innovation Accelerator Program (IAP) in July 2014 with the goal of improving health and health care for Medicaid beneficiaries by supporting the state's efforts to accelerate new payment and service delivery reforms.

The main goal of the initiative is to enhance CMS's wide ranging efforts to improve care by supporting system-wide payment and delivery system reform innovation. CMS is using the IAP to work closely with states, consumers, and health providers on critical issues through technical assistance, tool development and cross-state and national learning opportunities.

Medicaid Innovation Accelerator Program (IAP): Overview

- ***Reducing Substance Use Disorders (SUD):*** Under the SUD IAP, selected States received technical assistance (TA) designed to accelerate the development and testing of SUD service delivery innovations. New Jersey requested

TA around preparing behavioral health (BH) providers for transition from contracting to a FFS network and into an at-risk managed care entity.

- ***Beneficiaries with Complex Needs (BCN):*** Under the BCN IAP, NJ received TA in areas related to enhanced data analytics and payment reform. New Jersey built on its existing work targeting the young adult with opioid use and dependency issues with SUD and included this work in the SUD Continuum included in the 1115 Waiver renewal.
- ***Community Integration-Long Term Services and Supports:***
  - **Incentivizing Quality and Outcomes (IQO): Incentivizing Quality and Outcomes (IQO):** Under the Incentivizing Quality and Outcomes for LTSS IAP, selected states received technical assistance (TA) to design a quality initiative for incentivizing quality and outcomes for the long term services supports beneficiaries in the home and community based setting. New Jersey utilized this opportunity to redesign its home and community based services value based purchasing strategy as well as improve quality care for the MLTSS home and community based population.
  - **Medicaid Housing-related Services and Partnerships (CI-LTSS):** This IAP was designed to be intensive and hands-on in order to move selected states closer towards building collaborations with key housing partners. The lack of affordable and accessible housing is a significant barrier to community integration for people who use LTSS. Under this opportunity, NJ formed a collaborative workgroup with key housing partners to inform its 1115 Waiver renewal concept paper and to spur thinking around including supportive housing as a Medicaid covered benefit.
- ***Medicare-Medicaid Data Integration (MMDI):*** Medicare-Medicaid Data Integration (MMDI) is aimed to assist states in accessing and using Medicare data needed to improve care coordination for Medicare-Medicaid eligible beneficiaries. New Jersey is working towards developing a use case to use Medicare and Medicaid claims data to understand the impact of implementing the FIDE SNP and MLTSS benefit.
- ***Physical And Mental Health Integration (PMH):*** Under the Physical and Mental Health Integration (PMH) IAP, targeted program support was offered to states seeking to expand and/or refine existing physical and mental health integration efforts. New Jersey used this opportunity to gain insight into working effectively with Federally Qualified Health Centers (FQHCs).
- ***Data Analytics:*** The goal for this IAP opportunity is to support state Medicaid agencies in their delivery system reform efforts by improving data analytic capacity. CMS is offering technical support to NJ to help develop a publicly available web-based application that will allow for more-timely and in-depth analysis of the Medicaid program which will include eligibility data, fiscal data, quality of care and utilization data, and allow for customized analysis.

Community Based Care Management Demonstration

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

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

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

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

regarding service satisfaction and quality of life issues. The NCI-AD survey is important to NJ because data gleaned from survey participants can be measured, tracked, and applied to future State initiatives. The MACCs (Medical Assistance Customers Centers), MLTSS Steering Committee, PACE, NJ Hospital Association, AARP, and the Managed Care Organizations all have a vested interest in the continued completion and outcomes of this survey as this survey is in alignment with one of the major goals of the DMAHS Quality Strategy. New Jersey first partnered with NCI-AD in 2015 and surveyed over seven hundred people. In 2016, over nine hundred residents of the State were surveyed, including MLTSS NF and MLTSS home and community based residents, members in the Program of All-inclusive Care for the Elderly, and those in the Older Americans Act. Participants in the survey were individuals who have been receiving long term services and supports for a minimum of six months. Recipients were assessed regarding the outcomes of services they received with the goal of assisting the State to improve the quality of services and supports that are provided to NJ residents. Surveyors received annual training regarding the survey process inclusive of creating a positive survey experience, interview techniques for older adults and people with disabilities, the use of proxy assistance, and mandatory reporting requirements. The 2016 survey contained approximately ninety questions that included the domains of: home, relationships, service satisfaction, direct care workers, daily activities, physical environment, safety/security/privacy, community, everyday living, health and wellness, healthcare, future planning, and independence. New Jersey also created eleven questions unique to the State that addressed specific concerns relevant to NJ and its residents. These included the categories of member needs, in-home assistance, home delivered meals, and individualized plans of care. At the end of the survey interviewers received feedback and any unmet needs that the individual identified and wished to have addressed were noted and appropriate follow-up was performed. As participating states measure and track their own performance, NJ State-specific performance reports regarding core indicators are available for year over year comparison along with additional information regarding the NCI-AD survey process on the NCI-AD website, www.nci-ad.org.

CHAPTER 3 – SUMMARY OF KEY FINDINGS

This chapter provides a review of key findings from April 2016–December 2017 EQR activities, including the annual assessment of MCO operations, validation of performance measures, validation of QIPs, care management audits, MLTSS care management audits, and CAHPS surveys. ABHNJ, AGNJ, HNJH, UHCCP, and WCHP participated in all of these EQR activities.

2016 Annual Assessment of MCO Operations

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

The methodology was not changed from 2015 annual assessments. Staff interview questions were not provided prior to the onsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the onsite interview. The plan was provided with an opportunity to clarify responses and to provide requested documentation during the onsite.

The specific number of requirements for which each MCO is reviewed depends on its performance during the previous year's assessment. The annual assessment process allows for a partial review for MCOs that meet a minimum compliance rate of 85% in the previous review period. MCOs entering the market in NJ have two consecutive full assessments, and some elements (e.g., CM7, CM8, CM19, QM11, and MLTSS elements) are reviewed annually regardless of prior year's score. MCOs with a compliance rate less than 85% or which already had a partial review in the prior year's assessment undergo a comprehensive review of all requirements in the current year. MCOs with a compliance rate of 85% or better are subject to a partial review that focuses only on those areas that needed improvement, specifically, those elements that were either Not Met or Not Applicable during the previous review. 2016 included a full review of ABHNJ, which began operations in NJ in December 2014 and had a full review for the first time in 2015. WCHP was also subject to a full review in 2016 because in 2015 it received a compliance score less than 85%. 2016 also included partial reviews of AGNJ, HNJH, and UHCCP, as they underwent a full review in 2015 and received scores above 85%. This review evaluated each health plan on 14 standards based on contractual requirements (total of 211 elements). The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2016 is outlined in **Table 4**.

Table 4: 2016 Annual Assessment Type by MCO

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

Assessment Methodology

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

The review consisted of pre-onsite review of documentation provided by the plan as evidence of compliance with the 14 standards under review; onsite review of randomly selected files; onsite interviews with key staff and post-onsite evaluation of documentation and onsite activities. To assist in submission of appropriate documentation, IPRO developed the Annual Assessment of MCO Operations Review Worksheet. This document closely follows the MCO/State Contract and was developed to assess MCO compliance. Each element is numbered and organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract

reference. In 2016, one new element was added under each topic to assess the quality and completeness of pre-onsite documentation submission. The worksheet 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, 2015 to June 30, 2016.

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

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

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

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

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

Summary of Comparative Results

Table 5 displays a comparison of the overall compliance score for each of the five MCOs from 2015 to 2016. In 2016, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2016 compliance scores from the annual assessment ranged from 74% to 96% (**Table 5**). ABHNJ's compliance score increased 12 percentage points from 62% to 74% in 2016. WCHP's compliance score increased 15 percentage points to 87% in 2016 (**Table 5**). The review categories of Satisfaction and Enrollee Rights and Responsibilities showed MCO average scores of 100% compliance (**Table 6**). The review category with the lowest MCO average score was Efforts to Reduce Healthcare Disparities at 45% average in 2016, an increase of 32 percentage point from 13% in 2015. Compliance score averages stayed the same as or increased from 2015 to 2016 for all standards, except for the Utilization Management compliance score average, which decreased 5 percentage points from 93% in 2015 to 88% in 2016 (**Table 6**).

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

Table 5: Comparison of 2015 and 2016 Compliance Scores by MCO

MCO	2015 Compliance %	2016 Compliance %	% Point Change from 2015 to 2016
ABHNJ	62%	74%	+12
AGNJ	86%	94%	+8
HNJH	91%	93%	+2
UHCCP	91%	96%	+5
WCHP	72%	87%	+15

Table 6: 2015 and 2016 Compliance Scores by Review Category

Review Category	MCO Average 2015	MCO Average 2016
Access	71%	83%
Quality Assessment and Performance Improvement	81%	98%
Quality Management	57%	77%
Efforts to Reduce Healthcare Disparities	13%	45%
Committee Structure	60%	91%
Programs for the Elderly and Disabled	80%	86%
Provider Training and Performance	76%	87%
Satisfaction	100%[1]	100%
Enrollee Rights and Responsibilities	94%	100%
Care Management and Continuity of Care	85%	89%
Credentialing and Recredentialing	80%	94%
Utilization Management	93%	88%
Administration and Operations	93%	98%
Management Information Systems	88%	96%
TOTAL	**80%[2]**	**89%[2]**

[1] ABHNJ Satisfaction elements were not applicable for review, thus the compliance score is the average of AGNJ, HNJH, UHCCP, and WCHP.
[2] Total is the average of compliance scores listed in **Table 5**.

Figure 2 depicts compliance scores since 2014. Compliance scores for HNJH and UHCCP have remained above 90% for all three years. WCHP and ABHNJ compliance scores have increased each year since they began operations in NJ in 2014 and 2015, respectively.

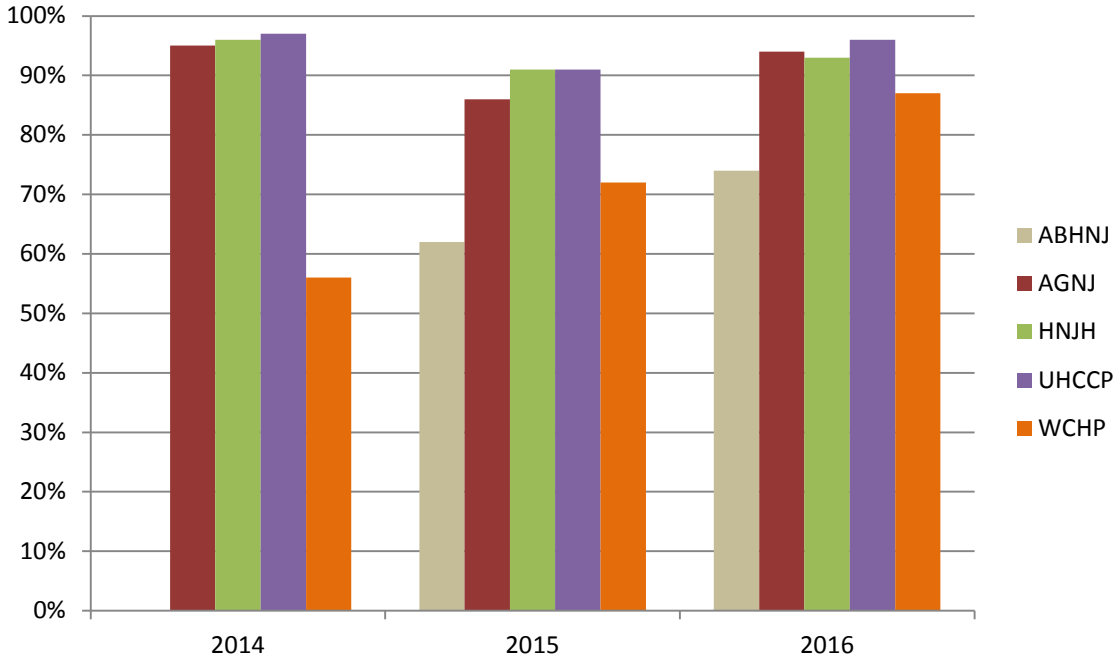

Figure 2: MCO Compliance Scores by Year (2014–2016). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, beige); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, green), UnitedHealthcare Community Plan (UHCCP, purple); and WellCare Health Plans of New Jersey, Inc. (WCHP, orange) are shown for 2014–2016. WCHP started services in 2014, and ABHNJ started in 2015.

Appendix: April 2016–December 2017 MCO-Specific Review Findings contains detailed information on each MCO's annual assessment.

MCO Strengths

The MCO's strengths are the valuable resources, capabilities, and distinguishing characteristics that it has developed or acquired over time. The individual MCO strength identified as a result of the 2016 annual assessment of MCO operations is listed below:

- Enrollee rights and responsibilities comprehensively documented and communicated to members and providers via the Member Handbook, Provider Manual and the health plan's website.

Opportunities for Improvement

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

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

- Development of strategies to ensure sufficient access to hospitals, dental services, and PCPs in all counties including access to and coverage of out-of-network services as necessary;
- Development of methods to monitor MLTSS HCBS provider network;
- Development, implementation, and formal evaluation of the outcomes of a work plan and initiatives to overcome identified healthcare disparities;
- Delineating provider complaints, grievances and appeals for processing and reporting purposes;
- Addressing study design and data collection deficiencies in the QIP process through staff training, including any new staff working on QIP projects;
- Development of a process to ensure timely development of a care plan for all members in Care Management; and
- Development of an annual MLTSS Care Management Program Description and Program Evaluation to be consistent with the contract year (July-June).

2017 Annual Assessment of MCO Operations

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

The methodology was not changed from 2015 annual assessments. Staff interview questions were not provided prior to the onsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the onsite interview. The plan was provided with an opportunity to clarify responses and to provide requested documentation during the onsite.

The specific number of requirements for which each MCO is reviewed depends on its performance during the previous year's assessment. The annual assessment process allows for a partial review for MCOs that meet a minimum compliance rate of 85% in the previous review period. MCOs entering the market in NJ have two consecutive full assessments, and some elements (e.g., CM7, CM8, CM19, QM11, and MLTSS elements) are reviewed annually regardless of prior year's score. MCOs with a compliance rate less than 85% or which already had a partial review in the prior year's assessment undergo a comprehensive review of all requirements in the current year. MCOs with a compliance rate of 85% or better are subject to a partial review that focuses only on those areas that needed improvement, specifically, those elements that were either Not Met or Not Applicable during the previous review. 2017 included a full review of ABHNJ, which began operations in NJ in December 2014 and had a full review for the first time in 2015 and received a compliance score less than 85% in 2016. AGNJ, HNJH, and UHCCP were also subject to a full review in 2017, as they underwent a partial review in 2016. WCHP had a partial review in 2017, as it had a full review in 2016 and received a score above 85%. This review evaluated each health plan on 14 standards based on contractual requirements (total of 216 elements). The assessment type applied to ABHNJ, AGNJ, HNJH, UHCCP, and WCHP in 2016 is outlined in **Table 7**.

Table 7: 2017 Annual Assessment Type by MCO

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

Assessment Methodology

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

The review consisted of pre-onsite review of documentation provided by the plan as evidence of compliance with the 14 standards under review; onsite review of randomly selected files; onsite interviews with key staff and post-onsite evaluation of documentation and onsite activities. To assist in submission of appropriate documentation, IPRO developed the Annual Assessment of MCO Operations Review Worksheet. This document closely follows the MCO/State Contract and was developed to assess MCO compliance. Each element is numbered and organized by general topics (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the Contract reference. In 2017, four new Quality Management elements and one new Efforts to Reduce Healthcare Disparities element were added. The worksheet 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, 2016 to June 30, 2017.

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

IPRO reviewers conducted onsite file reviews for all MCOs. Select files were examined for evidence of implementation of contractual requirements related to credentialing, recredentialing, and utilization management, as well as member and provider complaints, grievances, and appeals. Separate file sets were selected to review Core Medicaid and MLTSS requirements. File reviews utilized the eight and thirty file sampling methodology established by the NCQA.[3]

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

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

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

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

Summary of Comparative Results

Table 8 displays a comparison of the overall compliance score for each of the five MCOs from 2016 to 2017. In 2017, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP scored above NJ's minimum threshold of 85%. The 2017 compliance scores from the annual assessment ranged from 87% to 98% (**Table 8**). ABHNJ's compliance score increased 13 percentage points from 74% to 87% in 2017. WCHP's compliance score increased 11 percentage points to 98% in 2017 (**Table 8**). The review categories of Committee Structure and Enrollee Rights and Responsibilities showed MCO average scores of 100% compliance (**Table 9**). The review category with the lowest MCO average score was Efforts to Reduce Healthcare Disparities at 76% average in 2017, an increase of 31 percentage point from 45% in 2016. Compliance score averages stayed the same as or increased from 2016 to 2017 for all standards, except for the Satisfaction and Administration and Operations compliance score averages, which decreased 5 and 7 percentage points, respectively, from 2016 to 2017, but remained above 90% (**Table 9**).

Table 8: Comparison of 2016 and 2017 Compliance Scores by MCO

MCO	2016 Compliance %	2017 Compliance %	% Point Change from 2016 to 2017
ABHNJ	74%	87%	+13
AGNJ	94%	94%	0
HNJH	93%	91%	-2
UHCCP	96%	92%	-4
WCHP	87%	98%	+11

Table 9: 2016 and 2017 Compliance Scores by Review Category

Review Category	MCO Average 2016	MCO Average 2017
Access	83%	85%
Quality Assessment and Performance Improvement	98%	98%
Quality Management	77%	90%
Efforts to Reduce Healthcare Disparities	45%	76%
Committee Structure	91%	100%
Programs for the Elderly and Disabled	86%	90%
Provider Training and Performance	87%	96%
Satisfaction	100%	95%
Enrollee Rights and Responsibilities	100%	100%
Care Management and Continuity of Care	89%	95%
Credentialing and Recredentialing	94%	96%
Utilization Management	88%	88%
Administration and Operations	98%	91%
Management Information Systems	96%	97%
TOTAL	**89%**[1]	**92%**[1]

[1]Total is the average of compliance scores listed in **Table 8**.

Figure 3 depicts compliance scores since 2015. Compliance scores for HNJH and UHCCP have remained above 90% for all three years. WCHP and ABHNJ compliance scores have increased each year since 2015.

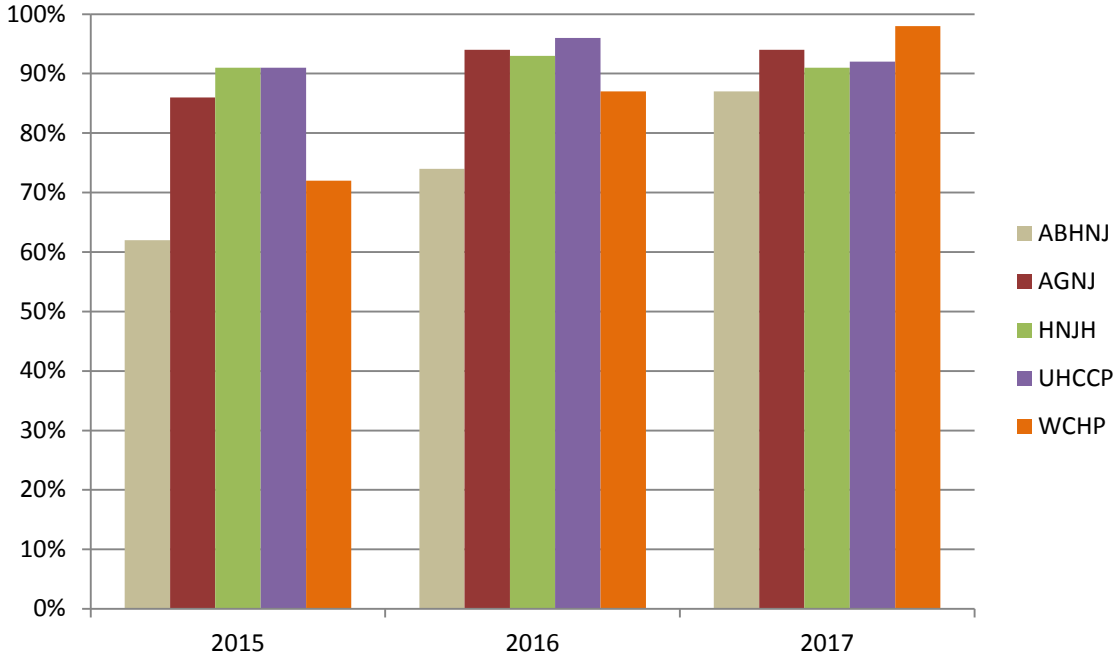

Figure 3: MCO Compliance Scores by Year (2015–2017). Compliance scores for Aetna Better Health of New Jersey (ABHNJ, beige); Amerigroup New Jersey, Inc. (AGNJ, red); Horizon NJ Health (HNJH, green), UnitedHealthcare Community Plan (UHCCP, purple); and WellCare Health Plans of New Jersey, Inc. (WCHP, orange) are shown for 2015–2017. ABHNJ started services in 2015.

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 2017 annual assessment of MCO operations are listed below:

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

Opportunities for Improvement

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

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

- Development of strategies to ensure sufficient access to hospitals, dental services, and PCPs in all counties including access to and coverage of out-of-network services as necessary;
- Development of methods to monitor MLTSS HCBS provider network;
- Formal evaluation of the outcomes of a work plan and initiatives to overcome identified healthcare disparities;
- Ensuring timely resolution of member and provider complaints, grievances and appeals and appropriate notification to the member and/or provider (note that complaints will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments);
- Addressing study design and data collection deficiencies in the QIP process through staff training, including any new staff working on QIP projects;
- Monitoring dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO; and
- Demonstration of timely member notification when a network provider terminates from the plan to ensure continuity of care.

2016 and 2017 Performance Measures

2016 Core Medicaid Performance Measures

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

Background

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

Assessment Methodology

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable. In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used and medical record review procedures relevant to the calculation of the hybrid measures. As a part of the assessment, IPRO also compared the MCOs' reported HEDIS results to national Medicaid 25th and 50th percentiles from NCQA's *Quality Compass*®, a widely accepted source of Medicaid benchmark data.

Evaluation Findings

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) and all demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State. A review of the FARs for the individual MCOs revealed that all procedures and databases used to produce HEDIS were determined to be compliant with the NCQA specifications and all measures that could be reported were deemed to be reportable.

IPRO compared the 2016 HEDIS rates to the NCQA Medicaid 25th percentile and the 50th percentile as reported in Quality Compass. There were no NCQA percentiles released for the Follow-up After Emergency Department Visit for Mental Illness rates and subpopulation results for the ambulatory care measures. In making these comparisons, IPRO presented the individual MCO rates for each of the PMs and compiled two averages. The first average, the NJ MCO average, is an MCO average derived by summing the rates for each measure across the MCOs with reportable rates and dividing by the

number of MCOs. The second average, the NJ Medicaid average, is a statewide average of the MMC population in NJ, calculated by summing the numerators and denominators for each administrative measure across the MCOs and by using a weighted average for the hybrid measures, weighted by the MCOs' eligible populations. HNJH did not complete the medical record review for hybrid measures for HEDIS 2016. HNJH's rates were not included in the NJ MCO or NJ Medicaid averages for measures that demonstrated potential bias greater than 10% (**Table 10**).

Overall, most measures remained constant from MY 2014 to MY 2015 (< 5 percentage point change) for the NJ Medicaid average. Significant improvements (≥ 5 percentage point increase) in performance from MY 2014 to MY 2015 were noted for Comprehensive Diabetes Care (Medical Attention for Nephropathy), BMI Assessment for Children/Adolescents (3–11 Years, 12–17 Years, and Total), Follow-up After Hospitalization for Mental Illness (30-Day Follow-up), and Adult BMI Assessment. For Follow-up After Hospitalization for Mental Illness (30-Day Follow-up), the rate was still below the 25th percentile despite the increase. Declines (≥ 5 percentage point decrease) in performance from MY 2014 to My 2015 were noted for Cervical Cancer Screening, Comprehensive Diabetes Care (Eye Exam and Blood Pressure Controlled < 140/90 mmHg), and Frequency of Ongoing Prenatal Care –81%+ of Expected Prenatal Visits.

Table 10: 2016 HEDIS Performance Measures

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Childhood Immunization (CIS)[3]							
Combination 2	N/A	73.78%	54.99%	65.69%	64.97%	68.15%	67.85%
Combination 3	N/A	67.05%	46.47%	59.37%	58.63%	61.68%	61.42%
Immunizations for Adolescents (IMA)							
Meningococcal	N/A	83.10%	85.30%	83.21%	76.81%	82.11%	84.22%
Tdap/Td	N/A	91.67%	93.93%	88.81%	84.78%	89.80%	91.85%
Combination 1	N/A	82.64%	84.03%	81.27%	74.15%	80.52%	82.81%
Lead Screening in Children (LSC)	N/A	75.64%	71.34%	75.67%	71.57%	73.56%	73.36%
Well-Child Visits in the First 15 Months of Life – 6 or More Visits (W15)[3]	N/A	68.84%	57.60%	64.96%	51.43%	61.74%	65.66%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	58.33%	80.89%	77.70%	76.74%	76.78%	74.09%	77.72%
Adolescent Well-Care Visits (AWC)	38.27%	65.97%	59.57%	56.59%	56.94%	55.47%	59.38%
Appropriate Testing for Children with Pharyngitis (CWP)	N/A	76.80%	64.19%	76.64%	67.98%	71.40%	70.30%
BMI Assessment for Children/Adolescents (WCC)[3]							
3–11 Years	66.67%	87.36%	45.49%	64.94%	57.78%	69.19%	70.08%
12–17 Years	N/A	85.96%	40.40%	58.57%	61.24%	68.59%	65.95%
Total	65.33%	86.81%	43.54%	62.77%	58.90%	68.45%	68.62%
Breast Cancer Screening (BCS)	N/A	49.31%	55.68%	55.84%	N/A	53.61%	54.98%
Cervical Cancer Screening (CCS)	29.61%	53.97%	52.07%	62.63%	45.14%	48.68%	55.37%
Chlamydia Screening (CHL)							
16–20 Years	N/A	57.51%	44.96%	56.31%	52.11%	52.72%	50.17%
21–24 Years	N/A	66.01%	55.06%	61.37%	61.67%	61.03%	58.57%
Total	N/A	61.45%	49.54%	58.57%	56.84%	56.60%	53.98%
Annual Dental Visit (ADV)							
2-3 Years	N/A	43.40%	48.69%	44.30%	47.36%	45.94%	46.57%
4-6 Years	N/A	62.77%	70.48%	69.45%	61.48%	66.05%	69.05%
7-10 Years	42.86%	67.12%	73.95%	73.09%	65.01%	64.41%	72.71%
11-14 Years	N/A	63.39%	69.02%	67.81%	59.51%	64.93%	67.74%
15-18 Years	N/A	53.57%	59.69%	57.49%	51.86%	55.65%	58.04%
19-20 Years	N/A	37.71%	46.85%	42.90%	25.64%	38.28%	43.83%

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Total	29.73%	58.56%	65.47%	63.71%	56.84%	54.86%	63.88%
Comprehensive Diabetes Care (CDC)							
HbA1c Testing	N/A	85.26%	80.47%	85.12%	85.84%	84.17%	82.74%
HbA1c Poor Control (> 9.0%)[3,4]	N/A	38.02%	49.45%	44.51%	43.06%	41.86%	42.81%
HbA1c Control (< 8.0%)[3]	N/A	52.09%	42.70%	45.62%	47.94%	48.55%	47.44%
HbA1c Control (< 7.0%) for a Selected Population[3]	N/A	38.79%	32.54%	34.78%	35.68%	36.42%	35.65%
Eye Exam	N/A	51.93%	50.00%	57.86%	55.22%	53.75%	52.87%
Medical Attention for Nephropathy	N/A	92.29%	91.42%	90.68%	88.90%	90.82%	91.13%
Blood Pressure Controlled < 140/90 mmHg[3]	N/A	49.25%	25.36%	57.30%	54.74%	53.76%	54.95%
Prenatal and Postpartum Care (PPC)							
Timeliness of Prenatal Care	80.47%	85.48%	79.08%	81.27%	78.24%	80.91%	80.72%
Postpartum Care	53.91%	55.50%	53.53%	61.56%	49.31%	54.76%	56.55%
Frequency of Ongoing Prenatal Care – 81+ Percent of Expected Prenatal Visits (FPC)[3]	57.81%	64.87%	58.77%	50.36%	55.09%	57.03%	54.49%
Follow-up Care for Children Prescribed ADHD Medication (ADD)							
Initiation Phase	N/A	32.31%	27.00%	39.38%	33.33%	33.01%	31.61%
Continuation and Maintenance Phase	N/A	34.43%	30.97%	42.96%	N/A	36.12%	35.32%
Follow-up After Hospitalization for Mental Illness (FUH)[5]							
30-Day Follow-up	N/A	57.63%	16.39%	69.63%	N/A	47.88%	46.79%
7-Day Follow-up	N/A	35.59%	5.74%	57.04%	N/A	32.79%	32.11%
Controlling High Blood Pressure (CBP)[3]	44.44%	66.36%	17.63%	49.88%	52.65%	53.33%	54.32%
Adult BMI Assessment (ABA)[3]	N/A	86.08%	42.82%	85.64%	72.04%	81.25%	85.74%
Annual Monitoring for Patients on Persistent Medications (MPM)							
ACE Inhibitors or ARBs	N/A	89.16%	86.47%	89.92%	92.33%	89.47%	88.02%
Digoxin	N/A	59.26%	53.94%	43.07%	N/A	52.09%	50.19%
Diuretics	N/A	88.53%	85.41%	89.30%	90.44%	88.42%	87.11%
Total	87.23%	88.74%	85.87%	89.27%	91.28%	88.48%	87.41%
Children and Adolescents' Access to Primary Care Practitioners (CAP)							
12–24 Months	N/A	95.68%	97.92%	97.42%	90.28%	95.33%	97.31%
25 Months–6 Years	82.22%	91.88%	93.52%	93.34%	90.20%	90.23%	93.20%
7–11 Years	N/A	93.05%	96.26%	95.08%	N/A	94.80%	95.51%

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
12–19 Years	N/A	90.11%	93.83%	92.93%	N/A	92.29%	93.08%
Human Papillomavirus Vaccine for Female Adolescents (HPV)[3]	N/A	20.83%	22.87%	20.19%	22.04%	21.02%	20.42%
Medication Management for People with Asthma (MMA)							
5–11 Years – 50% Compliance	N/A	48.63%	47.87%	46.70%	N/A	47.73%	47.60%
5–11 Years – 75% Compliance	N/A	23.97%	24.12%	23.39%	N/A	23.83%	23.90%
12–18 Years – 50% Compliance	N/A	48.47%	47.76%	46.99%	N/A	47.74%	47.61%
12–18 Years – 75% Compliance	N/A	22.01%	25.00%	23.86%	N/A	23.62%	24.36%
19–50 Years – 50% Compliance	N/A	58.06%	61.39%	55.89%	N/A	58.45%	59.73%
19–50 Years – 75% Compliance	N/A	35.78%	37.55%	31.26%	N/A	34.86%	35.81%
51–64 Years – 50% Compliance	N/A	63.10%	73.13%	72.60%	N/A	69.61%	71.98%
51–64 Years – 75% Compliance	N/A	44.64%	51.37%	51.23%	N/A	49.08%	50.60%
Total – 50% Compliance	N/A	52.91%	55.33%	51.84%	N/A	53.36%	54.15%
Total – 75% Compliance	N/A	29.17%	32.08%	28.43%	N/A	29.89%	30.79%
Ambulatory Care – Outpatient Visits per Thousand Member Months (AMB)[6]							
< 1 Year – Total Medicaid	544.29	738.75	1,124.45	816.42	532.26	751.23	953.27
1–9 Years – Total Medicaid	211.70	332.15	434.38	371.79	274.30	324.87	396.48
10–19 Years – Total Medicaid	143.39	249.32	308.50	261.65	201.32	232.84	282.25
20–44 Years – Total Medicaid	170.11	271.88	391.35	332.51	270.24	287.22	347.59
45–64 Years – Total Medicaid	285.37	488.03	652.44	560.25	572.76	511.77	592.23
65–74 Years – Total Medicaid	369.96	625.61	717.79	705.45	953.83	674.53	777.50
75–84 Years – Total Medicaid	573.80	522.77	679.49	543.85	1,081.82	680.34	765.23
85+ Years – Total Medicaid	610.81	469.35	668.16	209.86	1,141.10	619.86	618.42
Unknown – Total Medicaid	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Total Medicaid	221.91	335.97	448.16	379.99	434.45	364.09	409.17
< 1 Year – Dual-Eligibles	N/A	N/A	1,103.20	N/A	1,000.00	1,051.60	1,100.00
1–9 Years – Dual-Eligibles	N/A	N/A	153.85	416.67	N/A	285.26	280.00
10–19 Years – Dual-Eligibles	N/A	N/A	N/A	521.74	114.29	318.01	345.68
20–44 Years – Dual-Eligibles	149.43	N/A	236.02	469.95	541.15	349.14	506.88
45–64 Years – Dual-Eligibles	272.30	N/A	550.00	679.16	898.83	600.07	798.49
65–74 Years – Dual-Eligibles	221.12	N/A	377.05	718.35	989.89	576.60	874.66
75–84 Years – Dual-Eligibles	392.52	N/A	303.03	496.97	1,135.08	581.90	886.46

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
85+ Years – Dual-Eligibles	0.00	N/A	0.00	130.23	1,182.78	328.25	636.89
Unknown – Dual-Eligibles	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Dual-Eligibles	247.25	N/A	533.81	522.12	1,001.33	576.13	795.73
< 1 Year – Disabled	605.23	681.61	1,376.28	1,004.24	368.77	807.23	1,110.95
1–9 Years – Disabled	126.35	428.01	592.06	486.08	274.71	381.44	529.65
10–19 Years – Disabled	136.99	258.84	353.75	288.67	184.03	244.46	314.96
20–44 Years – Disabled	226.32	289.37	497.76	366.01	394.05	354.70	417.11
45–64 Years – Disabled	352.09	714.60	927.84	830.41	887.63	742.51	869.09
65–74 Years – Disabled	392.16	628.51	702.88	689.78	713.44	625.35	685.62
75–84 Years – Disabled	571.43	522.62	665.99	613.95	598.72	594.54	621.50
85+ Years – Disabled	434.74	469.35	649.80	517.24	540.59	522.34	568.07
Unknown – Disabled	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Disabled	304.98	478.32	670.93	548.22	587.83	518.06	602.00
< 1 Year – Other Low Income	543.84	739.34	1,100.20	814.60	535.60	746.72	940.34
1–9 Years – Other Low Income	213.42	329.76	423.62	368.52	274.29	321.92	389.47
10–19 Years – Other Low Income	143.52	248.78	301.52	260.07	202.31	231.24	278.07
20–44 Years – Other Low Income	169.52	270.44	376.67	329.58	247.14	278.67	338.52
45–64 Years – Other Low Income	283.89	446.38	575.93	509.28	449.86	453.07	526.29
65–74 Years – Other Low Income	404.74	482.76	835.48	661.10	406.02	558.02	530.94
75–84 Years – Other Low Income	628.81	600.00	928.57	187.50	0.00	468.98	603.65
85+ Years – Other Low Income	768.60	N/A	0.00	219.30	0.00	246.97	472.00
Unknown – Other Low Income	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Other Low Income	219.84	323.79	422.15	364.53	293.09	324.68	384.49
Ambulatory Care – Emergency Room Visits per Thousand Member Months (AMB)[6]							
Total – < 1 Years	89.55	91.29	108.73	76.26	88.93	90.95	95.50
Total – 1–9 Years	46.39	49.73	55.87	42.52	45.46	47.99	50.44
Total – 10–19 Years	37.45	35.71	43.59	34.88	30.73	36.47	39.41
Total – 20–44 Years	72.80	75.97	97.37	70.62	69.93	77.34	84.31
Total – 45–64 Years	56.39	62.68	74.04	61.61	57.74	62.49	67.52
Total – 65–74 Years	32.51	36.59	34.87	44.68	41.12	37.96	40.46
Total – 75–84 Years	15.06	29.06	29.56	40.64	41.92	31.25	37.69

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Total – 85+ Years	27.03	24.35	36.25	28.18	49.71	33.10	36.79
Total – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Total Years	60.92	57.94	68.55	52.56	53.48	58.69	61.35
Dual Eligibles – < 1 Years	N/A	N/A	113.88	N/A	0.00	56.94	110.34
Dual Eligibles – 1–9 Years	N/A	N/A	0.00	0.00	N/A	0.00	0.00
Dual Eligibles – 10–19 Years	N/A	N/A	N/A	21.74	0.00	10.87	12.35
Dual Eligibles – 20–44 Years	22.99	N/A	105.59	101.57	90.24	80.10	93.88
Dual Eligibles – 45–64 Years	18.78	N/A	60.00	94.15	79.29	63.05	85.18
Dual Eligibles – 65–74 Years	33.00	N/A	16.39	55.60	42.35	36.84	47.69
Dual Eligibles – 75–84 Years	28.04	N/A	90.91	46.97	42.75	52.17	44.38
Dual Eligibles - 85+ Years	0.00	N/A	0.00	26.22	51.66	19.47	38.46
Dual Eligibles – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – Total Years	26.10	N/A	87.26	58.15	55.15	56.67	56.50
Disabled – < 1 Years	78.95	109.74	149.41	137.20	89.7	113.00	136.51
Disabled – 1–9 Years	97.47	68.62	81.74	73.63	55.46	75.38	76.97
Disabled – 10–19 Years	68.49	52.26	68.94	57.10	43.38	58.03	62.17
Disabled – 20–44 Years	291.23	95.99	149.69	101.67	123.65	152.45	124.83
Disabled – 45–64 Years	196.14	114.38	136.98	116.95	108.27	134.54	127.32
Disabled – 65–74 Years	50.98	37.03	34.50	31.00	32.58	37.22	33.81
Disabled – 75–84 Years	10.2	28.98	29.54	31.27	34.58	26.91	30.27
Disabled – 85+ Years	21.47	24.35	36.99	32.13	21.59	27.31	32.07
Disabled – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Disabled – Total Years	143.87	86.64	113.77	88.66	86.29	103.85	101.23
Other Low Income – < 1 Years	89.63	91.10	107.44	75.67	88.97	90.56	94.61
Other Low Income – 1–9 Years	45.36	49.26	54.92	41.63	45.2	47.27	49.58
Other Low Income – 10–19 Years	36.82	34.77	41.95	33.59	30.03	35.43	38.01
Other Low Income – 20–44 Years	70.43	74.32	93.01	68.23	65.05	74.21	81.01
Other Low Income – 45–64 Years	53.38	53.17	59.24	50.95	44.76	52.30	55.00
Other Low Income – 65–74 Years	22.66	14.78	64.52	26.25	37.59	33.16	29.96
Other Low Income – 75–84 Years	13.85	66.67	107.14	0.00	0.00	37.53	20.50
Other Low Income – 85+ Years	33.06	N/A	0.00	175.44	0.00	52.12	96.00

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Other Low Income – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Other Low Income – Total Years	711.03	55.49	64.45	49.68	50.01	186.13	62.65

[1] New Jersey MCO Average uses only MCOs with an eligible population greater than or equal to 30.
[2] New Jersey Medicaid Average is the weighted average of all MCO data.
[3] HNJH did not complete the medical record review for hybrid measures for HEDIS 2016. HNJH's rates were not included in the NJ MCO or NJ Medicaid averages for measures that demonstrated potential bias greater than 10%.
[4] HbA1c Poor Control is an inverted measure. Higher rates for the HBA1c Poor Control measure indicate poorer performance.
[5] Follow-up After Hospitalization is only applicable to members who receive a behavioral health benefit. This is limited to the DDD population and the MLTSS population.
[6] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance.
Designation N/A: insufficient membership to report a rate (0 member months for the AMB measure, < 30 members in denominator for all other measures).
Designation CNC: unweighted averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.

Shading Key
Green: above 50th percentile
Yellow: below 50th percentile and above 25th percentile
Red: below 25th percentile
Light gray: there were no percentiles released by NCQA for this measure.

2016 New Jersey State-Specific Measures

As more patients with disabilities and chronic conditions transition to managed care from Fee-for-Service (FFS), three performance measures were developed by IPRO, in conjunction with DMAHS. These measures were derived from existing HEDIS performance measures to help monitor care for vulnerable populations, and can be used to identify areas in need of improvement for reducing disparities in care. These measures are: Adults' Access to Preventive/Ambulatory Health Services (AAP), Children and Adolescents' Access to Primary Care Practitioners (CAP), and Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit). Each measure is reportable by the total Medicaid population and by three subpopulations: Medicaid/Medicare Dual-Eligibles, Medicaid Disabled, and Other Low Income. Comparative NCQA national Medicaid benchmarks are provided for AAP and CAP measures, although there are no NCQA national Medicaid benchmarks for the subpopulations of these measures. As a proxy, subpopulation rates are compared to the NCQA national Medicaid benchmarks for the total Medicaid population. There are no comparative NCQA national Medicaid benchmarks provided for the Preventive Dental Visit measure, as this measure is specific to NJ.

All MCOs reported the required measures for MY 2015. For HNJH, the following should be considered for valid interpretation and comparison of HNJH's rates: although Medicaid members were excluded from HEDIS reporting using the TPL file, members were not excluded using the TPL file for reporting the NJ-specific measure, Preventive Dental Visit (therefore, the Dual Eligible subpopulation for this measure included Medicaid members with MMC, Medicare FFS, and commercial coverage). HNJH did not include the Dual Eligible membership in either the AAP or CAP measures, as Dual Eligible members were not included in their HEDIS population. For UHCCP, the following should be considered for valid interpretation and comparison of UHCCP's rates: FIDE-DSNP members were included in the HEDIS submission and excluded in the NJ-specific submission. UHCCP excluded non-UHCCP Medicare Dual Eligibles from reporting; however, as a result of a reporting error for the NJ-specific submission, non-UHCCP Medicare Dual Eligibles in MLTSS were included, and non-Dual Eligibles in MLTSS were excluded (which excluded an estimated 200 members in the Disabled subpopulation, impacting 1% of the denominator for the total Disabled subpopulation for AAP and Preventive Dental Visit; this did not affect the CAP measure).

The following results were noted for the NJ Medicaid average: For AAP, rate for Total Medicaid – Total was 81.86% in MY 2015; the total rate for Disabled was highest (86.20%), followed by Dual Eligible (86.08%), and Other Low Income (80.86%). For CAP, the rate for Total Medicaid – 12 Months–19 Years was 94.04% in MY 2015 and the Total Medicaid rates for all age cohorts were above the NCQA 50th percentile. For Preventive Dental Visit, the rate for Total – Total was 47.63% in MY 2015; the rate for Dual Eligibles – Total was 29.70%, Disabled – Total was 34.35%, and Other Low Income – Total was 50.62%.

Table 11: 2016 New Jersey State-Specific Performance Measures

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Adults' Access to Preventive/Ambulatory Health Services (AAP)							
Total Medicaid – 20–44 years	54.75%	72.13%	82.11%	77.47%	66.86%	70.66%	78.76%
Total Medicaid – 45–64 years	65.12%	80.94%	88.98%	85.06%	81.92%	80.40%	86.35%
Total Medicaid – 65+ years	68.18%	78.40%	87.68%	77.22%	91.57%	83.72%	85.49%
Total Medicaid – Total	59.30%	75.67%	84.87%	80.18%	79.37%	75.88%	81.86%
Dual Eligibles – 20–44 years	N/A	N/A	82.35%	85.71%	81.91%	83.81%	82.31%
Dual Eligibles – 45–64 years	50.00%	N/A	94.44%	83.86%	90.28%	87.07%	88.93%
Dual Eligibles – 65+ years	33.33%	N/A	75.00%	67.55%	92.35%	79.95%	85.74%
Dual Eligibles – Total	40.00%	N/A	87.18%	70.55%	91.15%	82.96%	86.08%
Disabled – 20–44 years	66.67%	65.97%	85.03%	75.14%	66.17%	73.08%	78.20%
Disabled – 45–64 years	70.00%	85.83%	93.93%	91.57%	88.97%	90.08%	92.07%
Disabled – 65+ years	73.68%	78.53%	87.67%	85.21%	84.20%	83.90%	85.29%
Disabled – Total	71.05%	76.91%	90.26%	84.19%	80.33%	80.55%	86.20%
Other Low Income – 20–44 years	54.33%	72.95%	81.79%	77.73%	65.45%	70.45%	78.81%
Other Low Income – 45–64 years	65.00%	79.62%	87.33%	83.40%	77.15%	78.50%	84.61%
Other Low Income – 65+ years	N/A	68.75%	89.13%	82.61%	71.43%	CNC	82.61%
Other Low Income – Total	58.45%	75.41%	83.74%	79.67%	70.29%	73.51%	80.86%
Children and Adolescents' Access to Primary Care Practitioners (CAP)							
Total Medicaid – 12–24 Months	72.73%	95.68%	97.92%	97.42%	90.28%	95.33%	97.32%
Total Medicaid – 25 Months–6 Years	82.22%	91.88%	93.52%	93.34%	90.20%	90.23%	93.20%
Total Medicaid – 7–11 Years	N/A	93.05%	96.26%	95.08%	80.95%	94.80%	95.51%
Total Medicaid – 12–19 Years	N/A	90.11%	93.83%	92.93%	79.17%	92.29%	93.08%
Total Medicaid – 12 Months–19 Years	79.10%	91.81%	94.64%	93.94%	90.10%	89.92%	94.04%
Dual Eligibles – 12–24 Months	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 25 Months–6 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 7–11 Years	N/A	N/A	0.00%	100.00%	N/A	CNC	66.67%
Dual Eligibles – 12–19 Years	N/A	N/A	N/A	100.00%	N/A	CNC	CNC
Total Dual Eligibles – 12 Months–19 Years	N/A	N/A	0.00%	100.00%	N/A	CNC	75.00%
Disabled – 12–24 Months	N/A	82.76%	95.88%	87.92%	46.67%	88.85%	90.11%
Disabled – 25 Months–6 Years	0.00%	88.31%	94.52%	92.81%	79.69%	88.83%	93.08%
Disabled – 7–11 Years	N/A	91.49%	97.21%	94.85%	100.00%	94.52%	95.90%
Disabled – 12–19 Years	N/A	84.74%	92.42%	91.05%	N/A	89.40%	91.01%

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Total Disabled – 12 Months–19 Years	0.00%	87.01%	94.32%	92.42%	73.75%	86.88%	92.80%
Other Low Income – 12–24 Months	72.73%	95.89%	97.95%	97.56%	91.41%	95.70%	97.43%
Other Low Income – 25 Months–6 Years	84.09%	91.97%	93.49%	93.35%	90.39%	90.66%	93.20%
Other Low Income – 7–11 Years	N/A	93.12%	96.22%	95.09%	80.00%	94.81%	95.49%
Other Low Income – 12–19 Years	N/A	90.52%	93.94%	93.06%	79.17%	92.51%	93.23%
Total Other Low Income – 12 Months–19 Years	80.30%	92.03%	94.66%	94.01%	90.42%	90.28%	94.10%
Preventive Dental Visit							
Total – 2–3 Years	25.00%	42.55%	48.36%	42.65%	47.37%	45.23%	45.83%
Total – 4–6 Years	17.24%	60.57%	67.89%	66.71%	59.62%	63.70%	66.52%
Total – 7–10 Years	42.86%	64.40%	70.20%	69.31%	62.77%	61.91%	69.14%
Total – 11–14 Years	36.36%	59.49%	63.69%	63.42%	56.69%	60.82%	62.96%
Total – 15–18 Years	35.71%	48.37%	52.63%	52.07%	47.62%	50.17%	51.83%
Total – 19–21 Years	2.86%	31.62%	37.90%	36.28%	23.54%	26.44%	36.22%
Total – 22–34 Years	21.51%	28.52%	35.47%	33.82%	26.80%	29.22%	33.85%
Total – 35–64 Years	21.37%	29.94%	36.71%	32.92%	30.14%	30.22%	34.65%
Total – 65+ Years	13.64%	18.53%	24.90%	20.23%	21.60%	21.32%	23.99%
Total – Total	22.43%	43.47%	48.46%	48.78%	36.94%	40.02%	47.63%
Dual Eligibles – 2–3 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 4–6 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 7–10 Years	N/A	N/A	0.00%	N/A	N/A	CNC	CNC
Dual Eligibles – 11–14 Years	N/A	N/A	100.00%	N/A	N/A	CNC	CNC
Dual Eligibles – 15–18 Years	N/A	N/A	0.00%	N/A	N/A	CNC	CNC
Dual Eligibles – 19–21 Years	N/A	N/A	41.79%	N/A	33.33%	CNC	41.54%
Dual Eligibles – 22–34 Years	N/A	N/A	35.38%	47.83%	31.88%	33.63%	35.22%
Dual Eligibles – 35–64 Years	0.00%	N/A	37.96%	34.46%	32.11%	34.84%	37.51%
Dual Eligibles – 65+ Years	0.00%	N/A	25.16%	22.95%	22.22%	23.44%	24.70%
Dual Eligibles – Total	0.00%	N/A	30.43%	25.15%	24.81%	26.80%	29.70%
Disabled – 2–3 Years	N/A	29.58%	40.19%	38.33%	38.46%	36.03%	38.42%
Disabled – 4–6 Years	0.00%	50.15%	60.01%	56.90%	56.86%	55.98%	58.05%
Disabled – 7–10 Years	66.67%	50.83%	61.48%	58.95%	57.14%	57.10%	59.59%
Disabled – 11–14 Years	50.00%	49.08%	53.80%	54.10%	43.06%	50.01%	53.11%
Disabled – 15–18 Years	N/A	36.08%	44.72%	43.40%	39.47%	40.92%	43.18%
Disabled – 19–21 Years	0.00%	23.99%	31.97%	31.14%	22.22%	27.33%	30.32%

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Disabled – 22–34 Years	20.00%	23.84%	30.94%	29.52%	25.74%	27.51%	29.27%
Disabled – 35–64 Years	7.14%	24.36%	31.06%	28.50%	28.79%	28.18%	29.43%
Disabled – 65+ Years	15.79%	18.45%	22.47%	17.94%	15.48%	18.59%	20.07%
Disabled – Total	17.39%	27.99%	36.29%	34.17%	28.39%	28.85%	34.35%
Other Low Income – 2–3 Years	25.00%	42.78%	48.52%	42.74%	47.46%	45.38%	45.98%
Other Low Income – 4–6 Years	17.86%	60.86%	68.18%	67.02%	59.69%	63.94%	66.80%
Other Low Income – 7–10 Years	40.63%	64.94%	70.62%	69.76%	63.05%	61.80%	69.57%
Other Low Income – 11–14 Years	35.00%	60.10%	64.30%	63.94%	57.52%	61.47%	63.55%
Other Low Income – 15–18 Years	35.71%	49.18%	53.16%	52.65%	48.17%	50.79%	52.41%
Other Low Income – 19–21 Years	3.03%	32.91%	38.78%	37.14%	23.70%	27.11%	37.13%
Other Low Income – 22–34 Years	21.56%	29.20%	36.02%	34.33%	26.51%	29.52%	34.37%
Other Low Income – 35–64 Years	22.48%	31.09%	37.70%	33.72%	29.92%	30.98%	35.39%
Other Low Income – 65+ Years	N/A	25.00%	25.00%	21.74%	33.33%	CNC	24.59%
Other Low Income – Total	23.06%	45.28%	52.27%	50.45%	42.70%	42.75%	50.62%

[1] New Jersey MCO Average uses only MCOs that had an eligible population greater than or equal to 30.

[2] New Jersey Medicaid average is the weighted average of all MCO data.

Designation N/A: plan had 0 members in the denominator.

Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

Shading Key
Green: above 50th percentile
Yellow: below 50th percentile and above 25th percentile
Red: below 25th percentile
Light gray: there were no percentiles released by NCQA for this measure.

2017 Core Medicaid Performance Measures

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

Background

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

Assessment Methodology

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS Final Audit Report (FAR) prepared by a NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable. In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used and medical record review procedures relevant to the calculation of the hybrid measures. As a part of the assessment, IPRO also compared the MCOs' reported HEDIS results to national Medicaid 25th and 50th percentiles from NCQA's *Quality Compass*, a widely accepted source of Medicaid benchmark data.

Evaluation Findings

IPRO validated the processes used to calculate the HEDIS PMs and ambulatory care utilization measures by the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) and all demonstrated the ability to accurately calculate and report the HEDIS measures to NCQA and to the State. A review of the FARs for the individual MCOs revealed that all procedures and databases used to produce HEDIS were determined to be compliant with the NCQA specifications and all measures that could be reported were deemed to be reportable.

IPRO compared the 2017 HEDIS rates to the NCQA Medicaid 25th percentile and the 50th percentile as reported in Quality Compass. There were no NCQA percentiles released for the Follow-up After Emergency Department Visit for Mental Illness rates and subpopulation results for the ambulatory care measures. In making these comparisons, IPRO presented the individual MCO rates for each of the PMs and compiled two averages. The first average, the NJ MCO average, is an MCO average derived by summing the rates for each measure across the MCOs with reportable rates and dividing by the number of MCOs. The second average, the NJ Medicaid average, is a statewide average of the MMC population in NJ, calculated by summing the numerators and denominators for each administrative measure across the MCOs and by using a weighted average for the hybrid measures, weighted by the MCOs' eligible populations. HNJH did not complete the medical record review for hybrid measures for HEDIS 2017. HNJH's rates were not included in the NJ MCO or NJ Medicaid averages for measures that demonstrated potential bias greater than 10% (**Table 12**).

All MCOs reported the required measures for MY 2016. The following should be considered for valid interpretation and comparison of reported rates: for AGNJ, Dual Eligible members, as well as FIDE SNP members were not included in the HEDIS submission (due to NCQA accreditation, FIDE SNP was excluded since it's a separate product managed by the AGNJ's Medicare business unit, and reported separately from Medicaid to the State and NCQA); for HNJH, non-FIDE SNP Dual Eligible members enrolled in their Medicare Managed Care Product were included in the HEDIS submission, based on the TPL Allocation Grid.

The following results were noted for the NJ Medicaid Average. Overall, rates remained relatively constant between MY 2015 and MY 2016 (with a < 5 percentage point change year over year) for most measures, although significant improvements in rates were reported for the Comprehensive Diabetes Care measure, for which rates increased by 6.79 percentage points for HbA1c Poor Control (> 9.0%), 7.17 percentage points for HbA1c Control (< 8.0%), and 6.80 percentage points for Eye Exam.

Table 12: 2017 HEDIS Performance Measures

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Childhood Immunization (CIS)							
Combination 2	41.35%	75.69%	70.32%	68.86%	61.80%	63.60%	70.20%
Combination 3	33.65%	67.82%	60.34%	61.80%	54.74%	55.67%	61.49%
Combination 9[3]	14.42%	35.42%	32.36%	31.14%	28.47%	28.36%	32.18%
Immunizations for Adolescents (IMA)							
Meningococcal	50.67%	81.02%	89.05%	86.37%	84.18%	78.26%	87.05%
Tdap/Td	73.33%	90.28%	89.54%	94.40%	90.75%	87.66%	91.14%
HPV[4]	8.00%	16.67%	20.44%	20.19%	19.71%	17.00%	19.86%
Combination 1	50.67%	78.70%	83.45%	84.91%	82.00%	75.95%	83.23%
Combination 2[3]	8.00%	15.28%	16.79%	18.00%	17.52%	15.12%	16.98%
Lead Screening in Children (LSC)	47.12%	69.91%	73.98%	81.02%	74.70%	69.34%	75.74%
Well-Child Visits in the First 15 Months of Life – 6 or More Visits (W15)	45.26%	61.64%	62.78%	59.74%	54.67%	56.82%	61.51%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	67.13%	79.23%	78.38%	74.72%	78.03%	75.50%	77.25%
Adolescent Well-Care Visits (AWC)	42.13%	58.99%	59.05%	63.21%	60.00%	56.67%	60.24%
Appropriate Testing for Children with Pharyngitis (CWP)	68.63%	81.47%	58.07%	80.26%	66.78%	71.04%	69.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)[3]							
BMI percentile - 3–11 Years	63.53%	88.52%	63.80%	76.63%	66.55%	71.81%	70.61%
BMI percentile - 12–17 Years	66.87%	85.80%	62.12%	71.53%	69.05%	71.07%	67.92%
BMI percentile - Total	64.81%	87.50%	63.26%	74.87%	67.32%	71.55%	69.68%
Counseling for Nutrition - 3-11 Years	60.90%	85.93%	60.93%	72.41%	64.79%	68.99%	67.36%
Counseling for Nutrition - 12-17 Years	69.88%	82.72%	63.64%	70.80%	69.84%	71.38%	68.20%
Counseling for Nutrition - Total	64.35%	84.72%	61.80%	71.86%	66.34%	69.81%	67.60%
Counseling for Physical Activity - 3-11 Years	51.50%	71.85%	54.48%	59.00%	45.42%	56.45%	57.60%
Counseling for Physical Activity - 12-17 Years	62.05%	79.63%	59.85%	70.80%	56.35%	65.74%	65.42%
Counseling for Physical Activity - Total	55.56%	74.77%	56.20%	63.07%	48.78%	59.67%	60.26%
Breast Cancer Screening (BCS)	N/A	52.11%	59.23%	58.89%	58.10%	57.08%	58.19%
Cervical Cancer Screening (CCS)	27.78%	57.31%	58.29%	64.69%	48.42%	51.30%	59.44%
Chlamydia Screening (CHL)							
16–20 Years	52.29%	58.55%	51.54%	57.32%	55.78%	55.10%	54.16%

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
21–24 Years	61.98%	69.46%	62.04%	63.37%	67.70%	64.91%	63.54%
Total	58.47%	63.70%	56.22%	60.02%	61.52%	59.99%	58.40%
Annual Dental Visit (ADV)							
2-3 Years	22.57%	43.99%	49.61%	46.36%	50.90%	42.68%	47.82%
4-6 Years	42.04%	63.37%	70.58%	72.14%	65.36%	62.70%	70.07%
7-10 Years	45.64%	67.99%	75.01%	75.10%	69.90%	66.73%	74.08%
11-14 Years	41.88%	64.60%	71.11%	70.62%	66.83%	63.01%	70.01%
15-18 Years	38.88%	54.99%	62.81%	61.17%	56.74%	54.92%	61.13%
19-20 Years	27.65%	38.75%	48.24%	46.77%	37.66%	39.81%	46.14%
Total	38.57%	59.41%	66.86%	66.28%	61.64%	58.55%	65.60%
Comprehensive Diabetes Care (CDC)							
HbA1c Testing	81.40%	87.15%	85.77%	87.78%	86.42%	85.70%	86.50%
HbA1c Poor Control (> 9.0%)[5]	52.17%	31.77%	37.04%	35.00%	37.58%	38.71%	36.02%
HbA1c Control (< 8.0%)	40.34%	58.51%	53.65%	55.69%	52.32%	52.10%	54.61%
HbA1c Control (< 7.0%) for a Selected Population	23.49%	41.13%	39.90%	40.21%	36.42%	36.23%	39.90%
Eye Exam	25.12%	54.51%	62.04%	58.75%	54.11%	50.91%	59.67%
Medical Attention for Nephropathy	89.61%	92.19%	88.50%	90.00%	90.53%	90.17%	89.42%
Blood Pressure Controlled < 140/90 mmHg[6]	42.75%	41.84%	52.74%	55.42%	48.21%	47.06%	51.32%
Prenatal and Postpartum Care (PPC)							
Timeliness of Prenatal Care	77.62%	85.35%	79.56%	83.94%	80.05%	81.30%	81.87%
Postpartum Care	56.64%	68.14%	56.69%	65.69%	60.83%	61.60%	61.48%
Frequency of Ongoing Prenatal Care – 81+ Percent of Expected Prenatal Visits (FPC)	49.30%	72.09%	54.61%	56.69%	58.88%	58.32%	58.05%
Follow-up Care for Children Prescribed ADHD Medication (ADD)							
Initiation Phase	N/A	32.90%	27.35%	39.52%	39.34%	34.78%	31.70%
Continuation and Maintenance Phase	N/A	39.02%	31.91%	44.08%	N/A	38.34%	36.77%
Follow-up After Hospitalization for Mental Illness (FUH)[7]							
30-Day Follow-up	N/A	47.06%	15.79%	67.43%	N/A	43.43%	43.19%
7-Day Follow-up	N/A	26.47%	5.26%	60.00%	N/A	30.58%	32.98%
Follow-up After Emergency Department Visit for Mental Illness (FUM)[3, 7]							
30-Day Follow-up	35.71%	52.29%	70.09%	N/A	N/A	52.70%	65.13%

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
7-Day Follow-up	28.57%	41.28%	54.17%	N/A	N/A	41.34%	50.51%
Controlling High Blood Pressure (CBP)[6]	36.73%	60.42%	39.66%	56.69%	41.46%	48.82%	56.01%
Adult BMI Assessment (ABA)[6]	60.54%	94.44%	75.18%	90.41%	70.15%	78.89%	90.34%
Annual Monitoring for Patients on Persistent Medications (MPM)							
ACE Inhibitors or ARBs	81.08%	90.25%	88.88%	91.16%	92.57%	88.79%	89.79%
Digoxin	N/A	60.00%	50.20%	52.91%	N/A	54.37%	52.52%
Diuretics	79.77%	89.31%	87.82%	90.09%	91.19%	87.64%	88.72%
Total	80.43%	89.71%	88.26%	90.45%	91.82%	88.14%	89.15%
Children and Adolescents' Access to Primary Care Practitioners (CAP)							
12–24 Months	88.89%	95.34%	97.89%	98.12%	94.46%	94.94%	97.49%
25 Months–6 Years	78.74%	91.48%	92.49%	93.56%	91.95%	89.65%	92.66%
7–11 Years	N/A	94.42%	95.88%	96.09%	96.16%	95.64%	95.79%
12–19 Years	77.42%	91.41%	93.57%	94.18%	93.30%	89.97%	93.49%
Medication Management for People with Asthma (MMA)							
5-11 Years – 50% Compliance	N/A	40.77%	53.02%	50.88%	41.67%	46.58%	51.02%
12-18 Years – 50% Compliance	N/A	46.56%	50.69%	50.34%	48.72%	49.08%	50.18%
19-50 Years – 50% Compliance	N/A	57.36%	64.19%	61.30%	59.81%	60.67%	62.83%
51-64 Years – 50% Compliance	N/A	66.52%	75.82%	75.32%	79.49%	74.29%	74.89%
Total – 50% Compliance	N/A	51.18%	59.89%	56.82%	60.66%	57.14%	58.28%
5-11 Years – 75% Compliance	N/A	22.54%	27.37%	25.67%	20.83%	24.10%	26.29%
12-18 Years – 75% Compliance	N/A	27.19%	26.09%	29.04%	23.08%	26.35%	26.94%
19-50 Years – 75% Compliance	N/A	30.20%	40.20%	40.77%	42.06%	38.31%	39.52%
51-64 Years – 75% Compliance	N/A	45.25%	53.64%	50.64%	46.15%	48.92%	51.89%
Total – 75% Compliance	N/A	29.59%	35.59%	33.93%	36.76%	33.97%	34.62%
Ambulatory Care – Outpatient Visits per Thousand Member Months (AMB)[8]							
< 1 Year – Total Medicaid	648.49	764.12	585.70	864.14	595.45	691.58	691.18
1–9 Years – Total Medicaid	271.98	343.05	468.90	387.50	305.10	355.31	422.77
10–19 Years – Total Medicaid	166.20	256.34	319.41	271.91	236.31	250.03	293.67
20–44 Years – Total Medicaid	180.71	284.76	380.50	341.38	305.89	298.65	348.69
45–64 Years – Total Medicaid	300.45	508.44	672.14	585.77	625.61	538.48	615.46
65–74 Years – Total Medicaid	374.76	690.82	829.18	866.76	861.64	724.63	824.94

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
75–84 Years – Total Medicaid	256.75	563.79	731.97	846.88	827.61	645.40	768.73
85+ Years – Total Medicaid	287.36	489.86	741.57	714.27	835.10	613.63	699.94
Unknown – Total Medicaid	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Total Medicaid	241.37	349.28	445.98	399.51	390.22	365.27	414.60
< 1 Year – Dual-Eligibles	N/A	NR	N/A	N/A	N/A	CNC	CNC
1–9 Years – Dual-Eligibles	N/A	NR	4,000.00	N/A	N/A	CNC	CNC
10–19 Years – Dual-Eligibles	0.00	NR	1,000.00	N/A	N/A	CNC	CNC
20–44 Years – Dual-Eligibles	96.87	NR	335.44	536.80	1,073.03	510.54	525.66
45–64 Years – Dual-Eligibles	350.79	NR	807.02	920.08	1,613.82	922.93	924.94
65–74 Years – Dual-Eligibles	213.46	NR	559.57	961.74	1,414.93	787.42	950.13
75–84 Years – Dual-Eligibles	117.51	NR	1,145.30	997.93	1,573.03	958.44	1,005.55
85+ Years – Dual-Eligibles	130.77	NR	1,892.05	925.51	1,756.41	1,176.18	977.51
Unknown – Dual-Eligibles	N/A	NR	N/A	N/A	N/A	CNC	CNC
Total – Dual-Eligibles	211.50	NR	909.36	921.77	1,506.74	887.34	921.66
< 1 Year – Disabled	392.52	642.16	1,262.04	1,107.92	625.00	805.93	1,051.83
1–9 Years – Disabled	322.22	411.33	619.30	506.94	338.97	439.75	552.94
10–19 Years – Disabled	155.76	255.50	373.39	311.20	234.57	266.08	335.26
20–44 Years – Disabled	326.84	303.16	515.75	364.41	508.99	403.83	435.43
45–64 Years – Disabled	565.23	735.76	983.21	821.56	1,039.23	829.00	910.63
65–74 Years – Disabled	471.92	693.13	781.71	702.73	755.99	681.10	735.53
75–84 Years – Disabled	328.78	563.22	703.05	633.26	671.79	580.02	654.32
85+ Years – Disabled	387.85	489.86	670.23	471.55	682.18	540.33	582.74
Unknown – Disabled	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Disabled	405.33	492.36	710.68	556.13	737.28	580.36	636.02
< 1 Year – Other Low Income	651.15	765.25	1,262.59	861.85	595.21	827.21	962.88
1–9 Years – Other Low Income	270.94	341.25	464.81	384.20	304.26	353.09	419.24
10–19 Years – Other Low Income	166.57	256.38	306.00	269.81	236.39	247.03	286.18
20–44 Years – Other Low Income	177.70	283.23	366.84	338.68	290.72	291.43	340.24
45–64 Years – Other Low Income	284.18	466.02	582.55	533.74	538.48	480.99	544.15
65–74 Years – Other Low Income	666.67	572.97	656.63	817.50	343.07	611.37	663.99
75–84 Years – Other Low Income	N/A	1,400.00	N/A	1,073.86	0.00	CNC	CNC

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
85+ Years – Other Low Income	0.00	N/A	191.36	1,429.69	0.00	405.26	878.32
Unknown – Other Low Income	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Other Low Income	234.57	337.04	424.00	378.10	345.86	343.91	393.62
Ambulatory Care – Emergency Room Visits per Thousand Member Months (AMB)[8]							
Total – < 1 Years	96.74	91.73	51.68	79.00	95.20	82.87	67.18
Total – 1–9 Years	50.58	48.80	62.40	42.83	49.57	50.84	54.19
Total – 10–19 Years	33.97	34.11	44.29	35.13	34.61	36.42	39.89
Total – 20–44 Years	69.04	71.86	101.94	71.30	76.22	78.07	87.04
Total – 45–64 Years	53.92	60.55	88.37	63.42	58.72	65.00	75.35
Total – 65–74 Years	20.24	36.23	49.60	50.64	39.38	39.22	47.34
Total – 75–84 Years	22.08	19.99	41.54	49.82	32.41	33.17	42.31
Total – 85+ Years	22.99	26.60	58.65	46.40	47.68	40.47	48.12
Total – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total – Total Years	58.16	55.65	72.79	53.27	58.31	59.64	63.95
Dual Eligibles – < 1 Years	N/A	NR	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 1–9 Years	N/A	NR	400.00	N/A	N/A	CNC	CNC
Dual Eligibles – 10–19 Years	0.00	NR	125.00	N/A	N/A	CNC	CNC
Dual Eligibles – 20–44 Years	34.19	NR	69.62	115.30	174.16	98.32	112.20
Dual Eligibles – 45–64 Years	22.22	NR	161.40	113.47	147.70	111.20	112.72
Dual Eligibles – 65–74 Years	7.39	NR	83.03	60.43	60.05	52.73	58.86
Dual Eligibles – 75–84 Years	14.39	NR	94.02	62.28	61.80	58.12	61.50
Dual Eligibles - 85+ Years	7.69	NR	221.59	56.42	89.74	93.86	62.50
Dual Eligibles – Unknown Years	N/A	NR	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – Total Years	15.29	NR	129.63	78.95	88.05	77.98	78.00
Disabled – < 1 Years	56.07	91.50	147.31	135.87	116.07	109.37	129.71
Disabled – 1–9 Years	62.96	66.61	96.15	78.32	59.19	72.65	86.25
Disabled – 10–19 Years	25.68	48.67	70.27	58.83	59.13	52.52	63.56
Disabled – 20–44 Years	158.76	86.69	162.51	105.07	154.09	133.43	133.09
Disabled – 45–64 Years	133.70	111.10	161.19	118.05	115.89	127.99	141.84
Disabled – 65–74 Years	26.77	35.98	45.86	33.66	32.13	34.88	39.18
Disabled – 75–84 Years	26.05	19.74	39.76	32.42	26.27	28.85	33.41

HEDIS Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Disabled – 85+ Years	32.71	26.60	50.71	34.57	40.93	37.11	41.43
Disabled – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Disabled – Total Years	90.95	81.37	129.11	90.67	96.79	97.78	110.21
Other Low Income – < 1 Years	97.17	91.73	110.97	78.47	95.03	94.67	93.30
Other Low Income – 1–9 Years	50.33	48.33	61.47	41.85	49.33	50.26	53.31
Other Low Income – 10–19 Years	34.26	33.30	41.45	33.86	33.44	35.26	37.92
Other Low Income – 20–44 Years	67.14	70.62	96.58	68.66	70.63	74.73	83.24
Other Low Income – 45–64 Years	49.58	51.12	69.45	52.28	47.01	53.89	60.58
Other Low Income – 65–74 Years	102.56	48.65	43.98	48.42	167.88	82.30	49.82
Other Low Income – 75–84 Years	N/A	400.00	N/A	51.14	0.00	CNC	CNC
Other Low Income – 85+ Years	0.00	N/A	43.21	85.94	0.00	32.29	64.16
Other Low Income – Unknown Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Other Low Income – Total Years	57.22	53.45	68.12	49.99	54.05	56.57	60.13

[1] New Jersey MCO Average uses only MCOs with an eligible population greater than or equal to 30.
[2] New Jersey Medicaid Average is the weighted average of all MCO data.
[3] Combination 9 (CIS), Combination 2 (IMA), Counseling for Nutrition and Counseling for Physical Activity (WCC), and Follow-up After Emergency Department Visit for Mental Illness (FUM) were new measures for HEDIS 2017.
[4] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents (IMA) measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.
[5] HbA1c Poor Control is an inverted measure. Higher rates for the HBA1c Poor Control measure indicate poorer performance.
[6] HNJH did not complete the medical record review for all hybrid measures for HEDIS 2017, resulting in potential bias for three hybrid measures: ABA, CBP, and CDC-Blood Pressure Controlled < 140/90 mmHg for a Selected Population. These measures demonstrated potential bias greater than or equal to 10%, therefore were excluded from the State weighted and unweighted averages.
[7] Follow-Up After Hospitalization for Mental Illness (FUH) and Follow-up After Emergency Department Visit for Mental Illness (FUM) were only applicable to members receiving a behavioral health benefit. This was limited to the DDD population and the MLTSS population.
[8] The eligible population for the AMB measure is the reported member months. Ambulatory measure rates are a measure of utilization rather than performance.
Designation N/A: insufficient membership to report a rate (0 member months for the AMB measure, < 30 members in denominator for all other measures).
Designation CNC: unweighted averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.

Shading Key
Green: above 50th percentile
Yellow: below 50th percentile and above 25th percentile
Red: below 25th percentile
Light gray: there were no percentiles released by NCQA for this measure.

2017 New Jersey State-Specific Measures

As more patients with disabilities and chronic conditions transition to managed care from Fee-for-Service (FFS), three performance measures were developed by IPRO, in conjunction with DMAHS. These measures were derived from existing HEDIS performance measures to help monitor care for vulnerable populations, and may be used to identify areas in need of improvement for reducing disparities in care. These measures are: Adults' Access to Preventive/Ambulatory Health Services (AAP), Children and Adolescents' Access to Primary Care Practitioners (CAP), and Preventive Oral Evaluations and Dental Services for Children and Adults (Preventive Dental Visit). Each measure is reportable by the total Medicaid population and by three subpopulations: Medicaid/Medicare Dual-Eligibles, Medicaid Disabled, and Other Low Income. Comparative NCQA national Medicaid benchmarks are provided for AAP and CAP measures, although there are no NCQA national Medicaid benchmarks for the subpopulations of these measures. As a proxy, subpopulation rates are compared to the NCQA national Medicaid benchmarks for the total Medicaid population. There are no comparative NCQA national Medicaid benchmarks provided for the Preventive Dental Visit measure, as this measure is specific to NJ.

All MCOs reported the required measures for MY 2016. The following should be considered for valid interpretation and comparison of reported rates. Dual Eligible members, as well as FIDE SNP members, were not included in AGNJ's HEDIS submission (due to NCQA accreditation, FIDE SNP was excluded since it's a separate product managed by AGNJ's Medicare business unit, and reported separately from Medicaid to the State and NCQA). A smaller eligible population was reported by WCHP for NJ-specific measures compared to the HEDIS AAP, CAP, and ADV measures, due to incarceration capitation codes not being included when the specifications for the NJ-specific measures were developed (**Table 13**).

The following results were noted for the NJ Medicaid average: For AAP, rates for Total Medicaid – Total 81.20% in MY 2016; the total rate for Dual Eligible was highest (96.46%), followed by Disabled (87.14%), and Other Low Income (79.93%). For CAP, the rate for Total Medicaid – 12 Months–19 Years was 94.09% in MY 2016; all rates calculated for age cohorts were above the NCQA 50th percentile across subpopulations (except the Disabled 12–24 Month cohort, which was between the NCQA 25th and 50th percentiles). For Preventive Dental Visit, the rate for Total – Total was 48.31% in MY 2016; the rate for Dual Eligibles – Total was 31.59%, Disabled – Total was 35.58%, and Other Low Income –Total was 51.76%.

Table 13: 2017 New Jersey State-Specific Performance Measures

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Adults' Access to Preventive/Ambulatory Health Services (AAP)							
Total Medicaid – 20–44 years	50.31%	70.89%	80.70%	77.67%	67.78%	69.47%	77.72%
Total Medicaid – 45–64 years	63.46%	79.76%	88.49%	85.67%	80.22%	79.52%	85.92%
Total Medicaid – 65+ years	66.84%	80.64%	89.81%	93.35%	86.17%	83.36%	90.08%
Total Medicaid – Total	55.47%	74.52%	83.89%	81.29%	74.18%	73.87%	81.20%
Dual Eligibles – 20–44 years	N/A	N/A	N/A	94.54%	N/A	94.54%	92.60%
Dual Eligibles – 45–64 years	N/A	N/A	N/A	97.72%	N/A	97.72%	96.83%
Dual Eligibles – 65+ years	43.08%	N/A	N/A	97.80%	97.50%	79.46%	96.78%
Dual Eligibles – Total	47.17%	N/A	85.00%	97.52%	96.30%	81.50%	96.46%
Disabled – 20–44 years	65.05%	67.07%	85.28%	77.37%	78.12%	74.58%	79.77%
Disabled – 45–64 years	78.57%	85.85%	93.98%	91.40%	89.64%	87.89%	92.09%
Disabled – 65+ years	78.81%	80.76%	89.92%	87.41%	85.40%	84.46%	87.42%
Disabled – Total	74.93%	77.65%	90.63%	85.50%	85.43%	82.83%	87.14%
Other Low Income – 20–44 years	49.97%	71.36%	80.26%	77.60%	66.65%	69.17%	77.50%
Other Low Income – 45–64 years	62.38%	78.28%	86.96%	83.96%	77.92%	77.90%	84.24%
Other Low Income – 65+ years	N/A	N/A	81.36%	94.87%	N/A	88.11%	85.60%
Other Low Income – Total	54.39%	73.93%	82.67%	79.84%	71.59%	72.48%	79.93%
Children and Adolescents' Access to Primary Care Practitioners (CAP)							
Total Medicaid – 12–24 Months	88.89%	95.34%	97.89%	98.12%	94.46%	94.94%	97.49%
Total Medicaid – 25 Months–6 Years	78.74%	91.48%	92.49%	93.56%	91.95%	89.65%	92.66%
Total Medicaid – 7–11 Years	N/A	94.42%	95.88%	96.09%	96.16%	95.64%	95.79%
Total Medicaid – 12–19 Years	77.42%	91.41%	93.57%	94.18%	93.29%	89.97%	93.49%
Total Medicaid – 12 Months–19 Years	81.94%	92.45%	94.12%	94.74%	93.61%	91.37%	94.09%
Dual Eligibles – 12–24 Months	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 25 Months–6 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 7–11 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Dual Eligibles – 12–19 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Total Dual Eligibles – 12 Months–19 Years	N/A	N/A	N/A	N/A	N/A	CNC	CNC
Disabled – 12–24 Months	N/A	78.00%	98.67%	95.83%	N/A	90.83%	94.91%
Disabled – 25 Months–6 Years	N/A	87.89%	93.57%	93.91%	87.88%	90.81%	92.91%
Disabled – 7–11 Years	N/A	93.62%	96.15%	95.99%	96.15%	95.48%	95.84%
Disabled – 12–19 Years	N/A	86.70%	92.06%	92.06%	90.61%	90.36%	91.39%

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Total Disabled – 12 Months–19 Years	76.67%	88.56%	93.70%	93.67%	91.57%	88.83%	93.06%
Other Low Income – 12–24 Months	88.92%	95.58%	97.88%	98.15%	94.57%	95.02%	97.52%
Other Low Income – 25 Months–6 Years	78.85%	91.56%	92.47%	93.55%	92.03%	89.69%	92.65%
Other Low Income – 7–11 Years	N/A	94.45%	95.87%	96.09%	96.16%	95.64%	95.79%
Other Low Income – 12–19 Years	76.67%	91.74%	93.67%	94.31%	93.45%	89.97%	93.63%
Total Other Low Income – 12 Months–19 Years	82.08%	92.62%	94.14%	94.78%	93.69%	91.46%	94.14%
Preventive Dental Visit							
Total – 2–3 Years	21.94%	43.21%	49.32%	45.79%	52.15%	42.48%	47.41%
Total – 4–6 Years	41.04%	61.71%	68.14%	70.39%	64.98%	61.25%	68.02%
Total – 7–10 Years	44.03%	65.86%	71.65%	72.73%	68.66%	64.59%	71.23%
Total – 11–14 Years	38.16%	61.33%	66.21%	67.41%	63.70%	59.36%	65.88%
Total – 15–18 Years	35.51%	50.35%	55.68%	56.22%	52.14%	49.98%	55.07%
Total – 19–21 Years	22.36%	33.15%	40.25%	40.86%	28.93%	33.11%	39.26%
Total – 22–34 Years	17.67%	27.25%	36.95%	36.11%	25.58%	28.71%	35.02%
Total – 35–64 Years	21.79%	29.52%	37.53%	35.89%	29.81%	30.91%	35.79%
Total – 65+ Years	19.81%	27.41%	27.10%	24.65%	19.27%	23.65%	26.23%
Total – Total	24.70%	42.42%	49.51%	49.21%	42.41%	41.65%	48.31%
Dual Eligibles – 2–3 Years	N/A	N/A	N/A	N/A	N/A	CNC	50.00%
Dual Eligibles – 4–6 Years	N/A	N/A	N/A	N/A	N/A	CNC	0.00%
Dual Eligibles – 7–10 Years	N/A	N/A	N/A	N/A	N/A	CNC	66.67%
Dual Eligibles – 11–14 Years	N/A	N/A	N/A	N/A	N/A	CNC	100.00%
Dual Eligibles – 15–18 Years	N/A	N/A	N/A	N/A	N/A	CNC	33.33%
Dual Eligibles – 19–21 Years	N/A	N/A	41.67%	37.59%	N/A	39.63%	39.63%
Dual Eligibles – 22–34 Years	N/A	32.85%	38.18%	37.00%	N/A	36.01%	37.54%
Dual Eligibles – 35–64 Years	32.00%	34.62%	39.45%	38.69%	N/A	36.19%	38.89%
Dual Eligibles – 65+ Years	23.33%	29.00%	27.65%	25.14%	N/A	26.28%	26.91%
Dual Eligibles – Total	25.32%	30.48%	32.46%	30.44%	N/A	29.67%	31.59%
Disabled – 2–3 Years	N/A	30.28%	43.04%	43.15%	N/A	38.82%	41.74%
Disabled – 4–6 Years	N/A	57.56%	57.97%	59.59%	37.50%	53.15%	58.12%
Disabled – 7–10 Years	N/A	53.20%	63.02%	61.14%	54.29%	57.91%	61.31%
Disabled – 11–14 Years	N/A	47.78%	55.96%	57.08%	39.71%	50.13%	55.18%
Disabled – 15–18 Years	N/A	39.48%	48.79%	46.58%	41.05%	43.97%	46.91%
Disabled – 19–21 Years	N/A	24.28%	33.68%	34.81%	25.00%	29.44%	32.45%

Measure	ABHNJ Reported Rate	AGNJ Reported Rate	HNJH Reported Rate	UHCCP Reported Rate[1]	WCHP Reported Rate	NJ MCO Average[1]	NJ Medicaid Average[2]
Disabled – 22–34 Years	27.66%	23.00%	32.76%	31.35%	30.56%	29.07%	30.87%
Disabled – 35–64 Years	27.27%	23.73%	31.58%	30.59%	26.68%	27.97%	30.21%
Disabled – 65+ Years	17.80%	17.94%	21.99%	19.77%	18.28%	19.15%	20.52%
Disabled – Total	24.28%	27.89%	37.23%	36.50%	27.66%	30.71%	35.58%
Other Low Income – 2–3 Years	22.04%	43.46%	49.45%	45.85%	52.05%	42.57%	47.52%
Other Low Income – 4–6 Years	41.49%	61.82%	68.49%	70.74%	65.57%	61.62%	68.35%
Other Low Income – 7–10 Years	44.70%	66.39%	72.06%	73.22%	69.21%	65.12%	71.68%
Other Low Income – 11–14 Years	38.09%	62.06%	66.80%	67.94%	64.69%	59.92%	66.48%
Other Low Income – 15–18 Years	35.56%	51.05%	56.12%	56.83%	52.79%	50.47%	55.59%
Other Low Income – 19–21 Years	23.79%	34.40%	41.01%	41.68%	29.40%	34.06%	40.10%
Other Low Income – 22–34 Years	17.47%	27.73%	37.34%	36.56%	25.00%	28.82%	35.36%
Other Low Income – 35–64 Years	21.31%	30.20%	38.37%	36.18%	30.41%	31.30%	36.30%
Other Low Income – 65+ Years	N/A	N/A	N/A	16.13%	N/A	16.13%	27.69%
Other Low Income – Total	24.71%	45.09%	53.05%	53.15%	44.35%	44.07%	51.76%

[1] New Jersey MCO Average uses only MCOs that had an eligible population greater than or equal to 30.

[2] New Jersey Medicaid average is the weighted average of all MCO data.

Designation N/A: insufficient membership to report a rate (< 30 members in denominator).

Designation CNC: an unweighted average can only be calculated if two or more MCOs have a rate.

Shading Key
Green: above 50th percentile
Yellow: below 50th percentile and above 25th percentile
Red: below 25th percentile
Light gray: there were no percentiles released by NCQA for this measure.

2016 and 2017 MLTSS Performance Measure Validation

During July 1, 2015–June 30, 2016, IPRO worked closely with NJ MLTSS staff and the MCOs to establish specifications for all MLTSS PMs reported by the MCOs. Specifications for the July 2016–June 2017 measurement period were developed for the following PMs:

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

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

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

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

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

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

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

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

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

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

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

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

PMs #35 and #36: Follow-Up After Mental Health Hospitalization for HCBS MLTSS Members
Assesses the percentage of discharges for eligible MLTSS HCBS members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit with a mental health practitioner. Two rates are reported: PM #35 assesses the percentage of members who received mental health follow-up within seven days of discharge, and PM #36 assesses the percentage of members who received mental health follow-up within 30 days of discharge. Reported quarterly and annually for reporting period July 2016–June 2017. Reported annually for prior reporting period.

PMs #37 and #38: Follow-Up After Mental Health Hospitalization for NF Members
Assesses the percentage of discharges for eligible MLTSS NF members who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit with a mental health practitioner. Two rates are reported: PM #37 assesses the percentage of members who received mental health follow-up within seven days of discharge, and PM #38 assesses the percentage of members who received mental health follow-up within 30 days of discharge. Reported quarterly and annually for reporting period July 2016–June 2017. Reported annually for prior reporting period.

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

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

Measures requiring claims have an 8-month lag from the last date of the measurement period to the reporting period, allowing for a 6-month claim lag, 1-month period for report development and 1 month for reporting. The timeframe for the MY 2016/2017 reports ran through February 2018, which is outside the scope of this report.

IPRO worked with the State and the MCOs to make modifications as necessary to the specifications for MY 2017/2018. These specifications were in for the period beginning July 1 2017. The reporting of the 7-Day Follow-up After Hospitalization (PM 35 and PM 37) was dropped for both the HCBS and NF populations. Four new PMs were added for the MY 2017/2018 period:

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

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

Results

The annual MCO rates for MY July 1, 2015–June 30,2016 for PM #4 Timeliness of Nursing Facility Level of Care Assessment varied from 81% to 95%, with a statewide rate of 91%. The rates for PM #20 Total Number of MLTSS Members Receiving MLTSS Services varied from 66% to 90%, with a statewide rate of 81%. The annual MCO rates for PM #21 MLTSS Members Transitioned from NF to Community ranged from 1% to 4%, with a statewide rate of 2%. The MCO rates for PM #22 New NF Living Arrangement for MLTSS Members ranged from 2% to 55%, with a statewide rate of 33%. Two MCOs had fewer than 30 cases to report annually for PM #23 NF to HCBS Transitions who Returned to NF within 90 Days. Transition rates for PM #23 for MCOs with at least 30 cases in the denominator ranged from 0% to 10%, with a statewide rate of 8%. MCO rates for PM #24 MLTSS HCBS Members Transitioned from the Community to NF for Greater than 180 Days ranged from 90% to 95%, with a statewide rate of 92% (by complement, PM #25 MLTSS HCBS Members Transitioned from the Community to NF for 180 Days or Less rate was 8%, with a range from 5% to 10%).

Acute Inpatient Utilization by MLTSS Members ranged from 32 to 59 events per 1,000 MM for HCBS members (PM #26) and from 12 to 56 events per 1,000 MM NF members (PM #27), while the statewide rates were 48 events and 38 events per 1,000 MM respectively. Readmissions of MLTSS HCBS (PM #28) and NF (PM #29) Members to Hospital within 30 Days ranged from 9% to 26% for HCBS members and from 11% to 26% for NF members, with statewide rates of 16% and 15%, respectively. ER Utilization by MLTSS Members ranged from 17 to 129 events per 1,000 MM for HCBS members (PM #30) and from 14 to 58 events per 1,000 MM for NF members (PM #31); statewide rates were 74 events and 34 events per 1,000 MM, respectively.

Measures #33, 34 and 41 evaluate the percent of HCBS members receiving only PCA, only medical day or both PCA and medical day services. In aggregate, MCO rates ranged from 20% and 42%, with a statewide rate of 26% of members falling into one of these three categories. Only one MCO had 30 or more cases in the denominator for Follow-up After Mental Health Hospitalization for HCBS MLTSS Members (PM #35 and PM #36) and no MCO had more than 30 cases in the denominator for Follow-up After Mental Health Hospitalization for NF MLTSS Members (PM #37 and PM #38). Statewide rates for 30-day follow-up were 64% for HCBS members (PM #36) and 63% for NF members (PM #38). MCO rates for MLTSS Members with Select Behavioral Heath Diagnoses ranged from 19% to 34% for HCBS members (PM #39), with a statewide rate of 27%. MCO rates for MLTSS Members with Select Behavioral Heath Diagnoses ranged from 42% to 61% for NF members (PM #40), with a statewide rate of 46%.

2016 and 2017 MLTSS Performance Measure 13

Performance Measure 13 evaluates delivery of MLTSS services to members compared with services identified in the Plan of Care (POC). This measure ensures HCBS MLTSS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. In 2016, IPRO evaluated the feasibility of producing PM 13 using administrative data rather than CM record review. The administrative methodology used authorizations data provided by each MCO as a proxy for the POC. IPRO obtained claims and authorizations data from each MCO, and conducted a preliminary comparison of claims to authorizations, whereby services in the authorization file were matched with services in the claims file to assess if the services were delivered as planned. IPRO also reviewed CM records from each MCO to assess whether authorizations data were a reasonable representation of the information contained in the POC.

The results of the preliminary claims/authorizations comparison and findings from the CM record review demonstrated that the administrative methodology was not a viable substitute for a comparison of claims against CM records. Differences in authorizations systems used by each MCO yielded inconsistencies in how changes to services were managed and how service units were used. CM record review revealed frequent discrepancies between POCs and authorizations data. Furthermore, it became apparent that an exclusively administrative approach is unable to detect any expected service delivery gaps. Delivery of home-based MLTSS services may be temporarily halted due to hospitalizations, extended family visits, non-custodial inpatient rehabilitations, patient preference, and other reasons. These cessations in delivery of service are not a reflection of MCO performance; however, a PM methodology using claims and authorizations data alone would incorrectly describe delivery of services as deficient compared to the authorizations file for any discontinued or reduced service, regardless of whether or not the service delivery discontinuation or reduction was appropriate.

It was concluded that the assessment of PM 13 requires a CM record review methodology, where POCs are compared to claims to determine if services were delivered appropriately.

In July 1, 2015–June 30, 2016, IPRO undertook an analysis POCs in the CM records and compared the services listed to services delivered as reflected by claims processed by the MCOs. MCOs were also given an opportunity to identify periods during which services were suspended due to member request or member absence from home due to hospitalizations or non-custodial rehabilitation stays (blackout periods).

A sample of 110 records was selected for each MCO. The MCOs submitted POCs, claims and blackout period information for these cases. Members were required to be enrolled in HCBS MLTSS with the MCO between July 1, 2015 and June 30, 2016.

Plan of Care Services Assessed

The list of MLTSS services assessed in this methodology is presented in **Table 14**. MLTSS services were identified in the MLTSS Service Data Dictionary. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services.

Table 14: MLTSS HCBS Services Assessed for Performance Measure 13

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

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

Performance Measure Methodology

Service data from the POCs was 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[4], and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC. Weeks were assigned from the first documented date of service and broken into 7-day intervals. If the end of the service span resulted in a partial week (i.e., if the end date of service did not fall on the last day of the 7-day interval), all days in the partial week were dropped from the timeline. Similarly, for monthly services, timelines were constructed using full months only; partial months at the end of the service span were dropped from the timeline. If there were any black-out periods or planned service discontinuations documented, these were removed from the timeline of expected services.

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

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

A total of 178 records were excluded, resulting in a study population of 372 members across all plans (**Table 15**). Records could be excluded for a number of reasons, including: 1) no POC submitted in the file, 2) POCs submitted did not have the necessary information to produce quantifiable expected services, and 3) POCs only documented services that were not evaluated for this measure, such as respite care or behavioral health services.

Table 15: MLTSS Performance Measure 13 Study Population

MCO	Total Sampled	Total Excluded	Study Population
ABHNJ	110	78	32
AGNJ	110	23	87
HNJH	110	23	87
UHCCP	110	19	91
WCHP	110	35	75
Total	550	178	372

Table 16 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 25.3%. As noted above, compliance with PM 13 was based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery had to exceed 95% for each service documented in the POC for each member. Of the 372 total members in the denominator, 94 (25.3%) received, on average, 95% of the planned service amount for all services documented in the POC.

Table 16: MLTSS Performance Measure 13 Compliance Rates

MCO	Denominator	Numerator	Compliance Rate
ABHNJ	32	11	34.4%
AGNJ	87	22	25.3%
HNJH	87	16	18.4%
UHCCP	91	25	27.5%
WCHP	75	20	26.7%
Total	372	94	25.3%

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

Table 17 shows the services that were evaluated for this measure, and the proportion of those services that were above the 95% average service delivery threshold. The denominators displayed in **Table 17** are the number of members that had the indicated service documented in their plan of care during the measurement period, while the numerators are the number of members whose average service delivery was above the 95% threshold. Note that a member may have appeared in more than one service.

Compliance for PM 13, shown in **Table 16**, is achieved when the 95% threshold is met for all services planned for that member. **Table 17** shows the number of services where the average service delivery exceeded the 95% threshold. **Table 17** provides an analysis of expected delivery of services at the service level.

Across all plans, the most common MLTSS service was PCA/Home Based Supportive Care; of the 248 members who had PCA/Home Based Supportive Care services planned, 68 (27.4%) received, on average, 95% or more of the planned amount (**Table 17**). Of the MLTSS services listed, Assisted Living was associated with the highest proportion of members reaching the 95% average threshold; of the 75 members who had Assisted Living services planned, 53 (70.7%) received on average at least 95% of the planned amount.

Table 17: MLTSS Services At or Above the 95% Average Service Delivery Threshold

	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			All MCOs		
Services Evaluated	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Adult Family Care	0	0		0	0		0	0		0	0		0	0		0	0	
Assisted Living	9	6	66.7%	23	16	69.6%	13	8	61.5%	27	21	77.8%	3	2	66.7%	75	53	70.7%
Chore Services	0	0		0	0		0	0		0	0		0	0		0	0	
Cognitive Therapy	0	0		1	1	100.0%	0	0		3	1	33.3%	0	0		4	2	50.0%
Community Residential Services	0	0		1	1	100.0%	0	0		2	1	50.0%	0	0		3	2	66.7%
Home Delivered Meals	10	1	10.0%	15	1	6.7%	21	6	28.6%	16	3	18.8%	14	7	50.0%	76	18	23.7%
Medical Day Services	2	1	50.0%	11	1	9.1%	15	3	20.0%	4	1	25.0%	27	6	22.2%	59	12	20.3%
Medical Transportation	0	0		0	0		1	0	0.0%	0	0		0	0		1	0	0.0%
Medication Dispensing Device Monthly Monitoring	2	0	0.0%	0	0		0	0		0	0		0	0		2	0	0.0%
Occupational Therapy	0	0		1	0	0.0%	0	0		2	0	0.0%	0	0		3	0	0.0%
PCA/Home Based Supportive Care	16	5	31.3%	47	11	23.4%	67	17	25.4%	54	13	24.1%	64	22	34.4%	248	68	27.4%
PERS Monitoring	10	4	40.0%	44	26	59.1%	29	8	27.6%	33	10	30.3%	23	10	43.5%	139	58	41.7%
Physical Therapy	0	0		4	0	0.0%	0	0		2	0	0.0%	0	0		6	0	0.0%
Private Duty Nursing	0	0		3	1	33.3%	2	0	0.0%	4	0	0.0%	0	0		9	1	11.1%
Social Adult Day Care	0	0		1	0	0.0%	0	0		0	0		0	0		1	0	0.0%
Speech, Language and Hearing Therapy	0	0		1	0	0.0%	0	0		0	0		0	0		1	0	0.0%
Structured Day Program	0	0		1	1	100.0%	0	0		1	0	0.0%	0	0		2	1	50.0%
Supported Day Services	0	0		0	0		0	0		1	0	0.0%	0	0		1	0	0.0%
TBI Behavioral Management	0	0		0	0		0	0		1	0	0.0%	0	0		1	0	0.0%

Gray shading: no rate was calculated, because denominator was zero.
D: denominator; N: numerator, %: rate.

Conclusion and Recommendations
This was the first year that the PM 13 was produced through review of CM records. Comparison of CM records to claims is the recommended methodology for producing this performance measure.

The overall compliance rate for PM 13 was 25.3% (**Table 16**). HNJH had the lowest compliance rate at 18.4%. The highest compliance rate was achieved by ABHNJ at 34.4%. However, it should be noted that ABHNJ had the lowest sample size of all the MCOs due to the high number of exclusions. The majority of ABHNJ records were excluded because a POC could not be located in the CM file.

Recommendations:
1. It was observed that claims are often submitted with incorrect procedure codes. It is recommended that MCOs review their coding practices to ensure that MLTSS services are billed appropriately. Claims submitted with an incorrect code or lacking a required modified should be denied back to the provider.
2. Authorizations and claims should accurately reflect the service recorded in the POC. Conflation of services such as PCA and HBSC should be addressed by ensuring that the authorization applies only to the service ordered in the POC.
3. MCOs should review CM files to ensure that POCs are complete and accurate. When POCs are not updated appropriately based on changes in conditions or changes in member needs, service delivery based on claims data may appear to be deficient. POCs should be amended whenever a change in services occurs.
4. MCOs should evaluate and standardize their processes for aligning authorizations with current POCs. It is recommended that when a service level is reduced or a service is terminated in the POC, that the corresponding authorization be termed and a new authorization be put in place which reflects the revised service level, in the case of reduced services. When service levels are increased in the POC, the MCO should terminate the current authorization at the lower level, and begin a new authorization for the increased level of service.

In 2017, IPRO undertook evaluation of PM 13 for the July 2016–June 2017 time period. MCOs were given a six-month lag period to submit claims for the measure. POC information was abstracted during the HCBS Care Management Audit. MCOs submitted blackout periods for members who were not receiving services due to member choice or member absence from the home. The same methodology was followed for this time period as was followed in the prior report. Results of the analysis will be provided to the State in 2018.

Core Medicaid/MLTSS Quality Improvement Projects

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

For April 2016–December 2017, the QTR reflects IPRO's evaluation of the June and September 2016 and 2017 QIP report submissions. IPRO's QIP validation process provides an assessment of the overall study design and implementation to ensure it met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols.

In 2013, AGNJ, HNJH and UHCCP began activities for a collaborative project addressing identification and management of obesity in adolescents; these QIPs were completed for three MCOs (AGNJ, HNJH and UHCCP) in 2017. WCHP submitted a QIP proposal addressing adolescent obesity in 2014, and is due to submit a final QIP pertaining to obesity in adolescents in 2018. In 2016 and 2017, MCOs continued to submit progress reports on the IPRO designed tool which captures all phases of QIP projects and all CMS protocol requirements for QIPs related to preterm birth rates (WCHP, AGNJ, HNJH and UHCCP) and 'Falls Prevention' for the MLTSS population (ABHNJ, AGNJ, HNJH, UHCCP and WCHP) . In September 2017, ABHNJ, AGNJ, HNJH, UHCCP, and WCHP submitted proposals for a new QIP, related to Improving Developmental Screening and Referral Rates for Early Intervention for Children Aged 0-3 Years.

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

Assessment Methodology

In accordance with article 4.6.2 (Q) – QIPs 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 QIPs to determine compliance with the CMS protocol, "Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Reviews (EQR)." IPRO assessed each QIP for compliance with the review categories listed below:

Review Element 1:	Project Topic and Topic Relevance
Review Element 2:	Study Question (Aim Statement)
Review Element 3:	Study Variables (Performance Indicators)
Review Element 4 & 5:	Identified Study Population and Sampling Methods
Review Element 6:	Data Collection Procedures
Review Element 7:	Improvement Strategies (Interventions)
Review Element 8 & 9:	Interpretation of Study Results (Demonstrable Improvement) and Validity of Reported Improvement
Review Element 10:	Sustainability of Documented Improvement

For each of the submitted QIPs, IPRO evaluated each of the Review Elements. For the proposed evaluations, IPRO reviewed elements 1 through 7.

In April 2016–December 2017, IPRO reviewed the reports and provided suggestions to the MCOs to enhance their studies. Each of the five MCOs submitted the following QIPs:

ABHNJ

QIP 1: Reduction in Falls Among Home and Community Based Members in MLTSS
QIP 2: Improving the Rate of Developmental Screening and Rate of Referral to Early Intervention Services for Children Aged 0-3 Years
During 2016 and 2017, the MCO submitted progress reports for QIP 1. The MCO submitted a proposal for QIP 2.

AGNJ

QIP 1: Identification and Management of Adolescents Overweight and Obesity
QIP 2: Reduction of Preterm Births – Increasing Progesterone Utilization Rates (ending project year 1 in 2016) and Reduction of Preterm Births by 5% (re-working of original project, establishing new baseline year of 2016, MY 1 in 2017, MY 2 in 2018 and sustainability year of 2019).
QIP 3: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population
QIP 4: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services for Members < 3 Years Old
During 2016 and 2017, the MCO submitted progress reports for QIPs 1–3 and a final report for QIP 1. The MCO submitted a proposal for QIP 4. During 2017, the MCO revised QIP 2 to include a new AIM statement and population of focus resulting in a new baseline and extending the duration of the project.

HNJH

QIP 1: Identification and Management of Obesity in the Adolescent Population
QIP 2: Improving Early Identification of Pregnancy and Birth Outcomes
QIP 3: Prevention of Recurrent Falls among Managed Long Term Services and Supports (MLTSS) Members
QIP 4: Developmental Screening and Early Intervention in Young Children

During 2016 and 2017, the MCO submitted progress reports for QIPs 1–3 and a final report for QIP 1. The MCO submitted a proposal for QIP 4.

UHCCP

QIP 1: Identification and Management of Childhood Obesity (Ages 12-17)
QIP 2: Preterm Births in Hudson County, NJ
QIP 3: Preventing Recurrent Falls in MLTSS Members with History of Falls
QIP 4: Early Intervention for Children in Lead Case Management (Age Birth to 3 Years Old)
During 2016 and 2017, the MCO submitted progress reports for QIPs 1–3 and a final report for QIP 1. The MCO submitted a proposal for QIP 4.

WCHP

QIP 1: Improving the Identification and Management of Pediatric Obesity in the 12-17 Year Old Medicaid Population
QIP 2: Reducing the Rate of Preterm Births in the NJ Medicaid Population
QIP 3: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall
QIP 4: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age
During 2016 and 2017, the MCO submitted progress reports for QIPs 1–3. The MCO submitted a proposal for QIP 4.

IPRO conducted half-day, in-person training workshops in July 2016 and 2017 at DMAHS. In 2015, a new QIP topic regarding fall prevention among the MLTSS population was introduced. In 2017, the development of an Early Intervention QIP along with the use of an enhanced Care/Case Management as a primary intervention was discussed. To address common issues within the June 2016 and June 2017 QIP submissions, IPRO conducted presentations related to data use, barriers, interventions, process measures, goal setting and other quality improvement principles. Representatives from the MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) participated in both trainings while DMAHS staff was in attendance. The training sessions included data exercises to be completed and presented by the MCOs to all of the meeting attendees.

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

Summary of QIP Performance

QIP Strengths

The collaborative obesity QIP remained ongoing in 2016 and was completed in 2017 by three MCOs. A common strength was that the MCO interventions were relevant to the identified MCO barriers as well as to the common barriers identified by all MCOs.

In September 2017, HNJH, UHCCP and WCHP submitted progress updates regarding the topic of "the reduction of preterm births." AGNJ revised their original QIP study by significantly revising their AIM statement and population of focus for purposes of overall quality improvement. All four plans had identified a population relevant to each MCO's project and contained strong rationale for their study. Interventions were identified based on continued barrier analysis.

Opportunities for Improvement

A common area noted for improvement across the QIP proposals of all five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP) was related to study design and data collection procedures including, but not limited to, identifying appropriate data sources, defining performance indicators, developing a method of collecting valid and reliable data and documenting a data analysis plan. IPRO reviewed these findings individually with each MCO to achieve improvement in these common areas.

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

Core Medicaid Encounter Data Validation

Encounter data validation (EDV) is an ongoing process, involving the MCOs, the State encounter data unit and the EQRO. It includes both a baseline evaluation and ongoing monitoring of submission patterns. 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.

On June 20, 2016, IPRO requested that DMAHS complete an information system capabilities assessment (ISCA) by July 30, 2016. The ISCA tool was developed by IPRO and based on CMS' ISCA tool developed on 5/1/2002. The review of the State's requirements and processes provided IPRO with a baseline assessment of the State's EDV process.

As a part of CMS's EDV protocol and first activity, IPRO reviewed DMAHS's Encounter Data Monitoring Unit (EDMU) requirements for collection and submission of encounter data. As of November 2016, IPRO has been attending the monthly MCO EDMU EDV calls. On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from Molina. IPRO loads the following data to IPRO's SAS data warehouse: member eligibility, demographic and third party liability (TPL) information and State-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation and vision encounter data.

The second activity of CMS's EDV protocol is the review of the MCO's capability to produce accurate and complete encounter data. The purpose of this activity is to determine the MCO's capability for collecting accurate and complete encounter data. Prior to examining data produced by the MCO's information system, the EQRO must determine whether the MCO's information system is likely to capture complete and accurate encounter data. IPRO assessed the MCO's information system through two steps:

1. review the MCO's ISCA, and
2. interview the MCO personnel.

On November 17, 2016, IPRO emailed the MCOs advising that they are required to complete the ISCA tool, which was uploaded to the File Transfer Protocol (FTP) site for each plan under the MCO's ISCA sub-folder. The MCOs were instructed that, in responding to the ISCA questions, they should include physical and behavioral health claim/encounters and exclude Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). The completed tool and all required attachments were requested to be uploaded to IPRO's FTP site under the MCO's ISCA sub-folder by December 30, 2016.

IPRO analyzed information from the MCO ISCA tools and conducted EDV onsite visits with the MCOs during January and February 2017. The purpose of the one-day onsite review was to:

1. review the ISCA responses with the appropriate MCO staff, and discuss any outstanding questions regarding the MCO's ISCA responses;
2. review MCO enrollment, claim/encounter and State encounter submission and reconciliation systems and processes; and
3. view member and claim examples selected from the 2016 NJ PM member-level data files based on HEDIS 2016 Adults' Access to Preventive/Ambulatory Health Services (AAP) and Children and Adolescents' Access to Primary Care Practitioners (CAP) on the NJ MCO's system screens.

The ISCA and the EDV onsite reviews were divided into four sections and focused on the following:

- enrollment systems,
- claim/encounter data system,
- reporting, and
- state encounter submissions.

Focused Quality Studies

2016 Focused Study #1: Developmental Screening, Medicaid Managed Care Enrollees

IPRO conducted one clinical focused study that was completed in 2016 on developmental screening. Formal developmental screening facilitates the timely identification of risk for developmental delay and referral for early intervention (EI) services, which is associated with improved long-term outcomes. The American Academy of Pediatrics (AAP) recommends developmental surveillance at each pediatric well-child visit with periodic formal developmental screening and appropriately addressing concerns as they are identified. The study focused on developmental surveillance, screening, follow-up and referral practice patterns among clinicians caring for NJ MMC-enrolled children between the ages of 1 and 3 years old in the GP, ABD and DCP&P eligibility populations. The objective was to assess developmental surveillance, formal developmental screening, follow-up actions for any identified surveillance concerns or abnormal developmental screens including the involvement of EI services, and MCO interventions in care or case management for children identified to be at risk for developmental delay (including coordination with EI). Risk factors for lack of screening and referral, particularly for EI services, were explored. Key indicators included documentation of abuse, neglect, birth-related abnormalities, family support structure, parental marital status, the language spoken by the parent or guardian, and environmental exposures such as lead and tobacco. Data sources for this study included PCP medical records, MCO care management and case management records, administrative data, and a survey of MCOs.

Data Sources: Record Procurement and Review

Medical records were requested from primary care providers associated with the latest identified well-child visit between July 1, 2014 and June 30, 2015. The review period (RP), specific to each child, included the year prior to and six months following each child's first, second, or third birthday in the measurement year. Medical records were collected and comprehensively reviewed for indication of developmental delay risks, surveillance, screening, and the extent of risk identification, follow-up, and documentation of barriers to follow-up. For children in EI, records were reviewed to evaluate MCO care manager and/or case manager coordination with the member, physician, and EI as documented in the care management and case management records. For records with identified concern, plan activities relating to EI, including referral to specialists or to EI programs were evaluated. Care management and case management records were comprehensively reviewed for indication of MCO care coordination, member and physician interactions, details on case referral, identification, and assessment of needs, plans regarding developmental concerns and associated risk factors, involvement with EI services, follow-up as appropriate, and documentation of barriers.

Summary of Findings

Overall, the majority of children in each age group evaluated for the prevalence of developmental delay had some degree of developmental surveillance, and most of those with surveillance were comprehensively assessed for all four domains of developmental surveillance (motor, cognitive, language and social-emotional), in accordance with established guidelines. Fewer children had broad developmental screening with a standardized tool. For developmental trajectory and milestone progression, 30% of one- and two-year-olds and 22% of three-year-olds had sufficient medical record documentation; all children should have documentation of these indicators of developmental surveillance. Developmental risks or concerns were identified among 17% of all children with developmental surveillance, and all with a risk or concern had at least one type of AAP-recommended follow-up documented. Surveillance is a continuous process; a primary component includes elicitation of parental concerns, which was documented for 38% of children with developmental surveillance.

The AAP recommends the use of periodic administration of standardized, global screening tools to improve the identification of developmental delays. Standardized screening was less prevalent than surveillance: 12% of children had evidence of standardized, global screening in the year preceding their first, second or third birthdays. Overall, standardized developmental screening rates were 12% for at least one global screen and 14% for at least one domain/condition-specific screen (which are appropriate for screening a particular area or condition; these are not generalized for any developmental concern or risk). Among those with at least one global developmental screen, 75% had the screening result documented in the provider record, of which 23% found an abnormality. Among those with at

least one domain/condition-specific screen, 73% had the screening result documented in the provider record, of which 7% found an abnormality.

Hearing and vision screening, and lead exposure assessment can detect children at risk of developmental delay. Documentation in the provider record for hearing and vision screening indicated that 58% and 53% of children were screened, respectively. Lifetime blood lead screening results revealed that 79% of the population had screening performed.

In order to assist in coordinating care for at-risk children, care managers and case managers must first engage the family. Care management and case management member outreach attempt rates, as well as successful contact rates, were higher for the ABD and DCP&P eligibility groups than for the GP group. Overall, 42% of care management and case management records documented outreach to, or contact with, the child's PCP. All children should have outreach, especially those children in the DCP&P eligibility group for whom care management enrollment is required; the rates for the GP group were low compared to observed prevalence of diagnoses that would trigger presumptive EI eligibility. The overall rate of care management and case management enrollment was 12%; enrollment rate was higher for the ABD (56%) and DCP&P (72%) groups, whereas it was 2% for the GP. Rates of care management and case management enrollment were high (98%) for those children identified as having a developmental concern or delay.

Care management and/or case management records lacked documentation of lead exposure assessment: 2% of children had documentation in the care management and/or case management record of a lead assessment, despite 79% of children in the study with a lead screening claim, and 1% of children had a laboratory value/result documented in the care management and/or case management record. Similarly, care management and/or case management records lacked documentation of EI engagement: 3% of children with care management and/or case management documentation within the RP had any documentation of EI engagement, despite 75% of children with enrollment in EI with at least one claim for EI services.

2016 Focused Study #2: Developmental Screening, Medicaid Managed Care Enrollees

Comprehensive well-child care includes surveillance and screening for developmental disorders. Monitoring for developmental disorders is especially important for children enrolled in MMC, who have a nearly two-fold higher prevalence of developmental delay compared to children who are privately insured. There is evidence in published reports that developmental delays are often not identified in a timely manner, with some children not identified with developmental problems until school entry, past the point at which early intervention is most effective. Formal developmental screening facilitates the timely identification of risk for developmental delay and referral for Early Intervention (EI) services, which is associated with improved long term outcomes.

Based on the findings of the aforementioned 2016 Focused Study #1 on Developmental Screening of MMC Enrollees, it was determined that further study was warranted to understand and assess the interface of EI services provision with care management, case management and lead case management. The scope of Study #2 encompasses MCO care management and case management for the general population for children who are either potentially in need of EI services or are receiving EI services, as well as children involved with lead case management. The need for EI services is established when a child is not receiving them, but referred to EI services following a confirmation of presumptive eligibility, risk of developmental delay, or abnormal indicator identified by developmental surveillance. The potential need of EI is when a child has not been receiving (or referred to) EI services despite an indicator (at least one triggering diagnosis that presumes EI eligibility, chronic condition associated with risk of developmental delay, or documentation of a toxic environmental exposure). Risk factors for lack of screening and referral, particularly for EI services, are assessed by Study #2. Furthermore, this study assesses the policies, processes, and procedures undertaken by MCOs to identify candidates for EI or members receiving EI services, and the roles played by care managers, case managers, and lead case managers in coordinating services for members receiving, or identified as in need of, EI services.

The methodology for Study #2 involves: MCO care management, case management, and lead case management record abstraction; administrative data, including rosters, member demographics, encounters/claims, medical and behavioral diagnoses which trigger presumptive eligibility, chronic conditions that confer risk for developmental delay, and lead

screening; and a survey of MCOs on their policies and procedures to identify candidates for EI and on how administrative data is used for EI services. MCO-generated rosters of members enrolled in case management, care management and lead case management are integrated into a request for each MCO to provide internal records on care management, case management, and lead case management for eligible members, from which the record-based information is abstracted and merged with the other data sources. In addition to the record review, EI services, presumptive diagnoses and enrollment in care management, case management and lead case management for the general population, using MCO encounter data and EI claims data, will be described for population-level analyses.

CAHPS 2016 Survey

IPRO subcontracted with a certified survey vendor to field the CAHPS surveys for the Medicaid population. Five Medicaid adult surveys were fielded; one for each of the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP). Five Medicaid child surveys were fielded; one for each of the five MCOs (ABHNJ, AGNJ, HNJH, UHCCP, and WCHP), which combines Medicaid and CHIP enrollment for each MCO. In addition, one statewide CHIP-only survey was conducted. All of the members surveyed required continuous enrollment from January 1, 2016 through June 30, 2016, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

The survey drew, as potential respondents, adult enrollees over the age of 18 years or parent/caretakers of child enrollees under the age of 18 years (as applicable) who were covered by NJ FamilyCare. Respondents were surveyed in English and Spanish. Spanish language materials were available upon request and were available with the second survey mailing and phone follow-up phases. The survey was administered over a 10-week period using a mixed-mode (mail and telephone) protocol. The four-wave protocol consisted of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and second reminder postcard to non-respondents, and finally a phone follow-up to non-respondents for whom IPRO had a valid telephone number.

For the adult survey, a total random sample of 8,105 cases was drawn of adult enrollees from the NJ FamilyCare plans. This consisted of a random sample of 1,621 enrollees from each plan. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 1,899 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult response rate was 24.3%. Composite results of the adult FamilyCare overall weighted positive responses for the five MCOs were: 90.5% for how well doctors communicate; 85.2% for customer service; 78.5% for shared decision making; 77.5% for getting needed care; and 75.3% for getting care quickly.

For the child survey, a total random sample of 9,415 cases was drawn of parent/caretakers of child enrollees from the NJ FamilyCare plans. This consisted of a random sample of 1,883 enrollees from each plan. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 2,115 parent/caretakers of NJ FamilyCare child enrollees, and the NJ FamilyCare child response rate was 22.9%. Composite results of the Child FamilyCare overall weighted positive responses for the five MCOs were: 91.6% for how well doctors communicate; 84.9% for customer service; 84.7% for getting care quickly; 82.7% for getting needed care; and 77.6% for shared decision making.

For the CHIP survey, a total random sample of 1,883 cases was drawn of parent/caretakers of CHIP child enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete interviews were obtained from 646 parent/caretakers of NJ FamilyCare CHIP enrollees and the NJ FamilyCare CHIP response rate was 34.8%. Composite results of the CHIP FamilyCare overall statewide positive responses were: 93.0% for how well doctors communicate; 87.3% for getting care quickly; 83.9% for getting needed care; 82.1% for customer service; and 80.6% for shared decision making.

CAHPS 2017 Survey

Results from the HEDIS-CAHPS 5.0H Survey for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following three survey vendors conducted the adult and child surveys on behalf of NJ FamilyCare: Center for the Study of Services, DSS Research, and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2016 through December 31, 2016, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult and child surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

The survey drew, as potential respondents, adult enrollees over the age 18 years, who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2017 using a mixed-mode protocol. All five health plans utilized a mail and telephone protocol. Additionally, ABHNJ offered the option to complete the survey via the internet. No adult survey respondents completed the survey via the internet option; one child survey respondent completed the survey via the internet option. The four-wave protocol consisted of an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and second reminder postcard to non-respondents, and finally a phone follow-up to all members who had not responded to the first two survey mailings.

For the adult survey, a total random sample of 9,248 cases was drawn of adult enrollees from the NJ FamilyCare plans. This consisted of a random sample of 1,350 ABHNJ enrollees, 1,755 AGNJ enrollees, 1,755 HNJH enrollees, 1,890 UHCCP enrollees, and 2,498 WCHP enrollees. To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 2,045 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult response rate was 22.7%. Composite results of the adult FamilyCare overall weighted positive responses for the five MCOs were: 90.8% for how well doctors communicate; 88.1% for customer service; 81.1% for getting needed care; 79.2% for getting care quickly; and 77.3% for shared decision making.

For the child survey, a total random sample of 10,957 cases was drawn of parent/caretakers of child enrollees from the NJ FamilyCare plans. This consisted of a random sample of 1,650 ABHNJ enrollees, 2,145 AGNJ enrollees, 1,667 HNJH enrollees, 2,310 UHCCP enrollees, and 3,185 WCHP enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 2,368 NJ FamilyCare child enrollees, and the NJ FamilyCare child response rate was 21.9%. Composite results of the Child FamilyCare overall weighted positive responses for the five MCOs were: 90.8% for how well doctors communicate; 85.6% for customer service; 84.7% for getting needed care; 82.9% for getting care quickly; and 71.1% for shared decision making.

For the CHIP survey, a total random sample of 2,145 cases was drawn of parent/caretakers of CHIP child enrollees. To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least six months prior to the sample selection with no more than one enrollment gap of 45 days or less. Complete surveys were obtained from 728 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP response rate was 34.7%. Composite results of the CHIP FamilyCare overall statewide positive responses were: 94.3% for how well doctors communicate; 86.3% for getting care quickly; 85.4% for getting needed care; 85.1% for customer service; and 75.1% for shared decision making.

Care Management Audits

Core Medicaid Care Management Audits

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

The audits focused on identification, outreach, preventive services, continuity of care, and coordination of services for each population. The audit reports contained the findings of IPRO's 2016 audit with comparisons to 2015 audit results.

Assessment Methodology

IPRO identified the specific populations using enrollment and eligibility; removed the enrollees with TPL from the DDD, DCP&P and GP populations; and generated the random sample for each MCO. For the General Population, IPRO conducted the audits for 2016 onsite at each MCO's office in March and April 2017 for by reviewing each MCO's CM files for the selected members. An off-site desk audit was carried out for the DDD and DCP&P populations. An electronic, standardized data collection tool was used.

Following the audit, IPRO aggregated the MCOs' results by population and prepared audit reports. MCOs were not permitted to submit additional information after the onsite audit.

Summary of Audit Performance

Table 18 provides the results for the MCOs with comparisons to the previous year's findings. Shaded rates indicate scores that are at or above 90%. The 2016 rates across all MCOs, populations, and categories ranged from 65% to 100%. Scores for Continuity of Care and Coordination of Services were above 90% for all five MCOs for all (GP, DDD, DCP&P) populations in 2016. Scores for Identification for the DDD and DCP&P populations were all above 90% across all five MCOs in 2016.

Five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) were evaluated for each population (DDD, DCP&P, and GP) within five participating MCOs (ABHNJ, AGNJ, HNJH, UHCCP and WCHP), for a total of 75 scores (**Table 18**). Out of the five metrics (Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services) across the General, DDD and DCP&P populations and across five plans that were comparable to 2015 (75 in total), forty-one (41) scored higher, twenty-three (23) remained the same, and eleven (11) scored lower in 2016.

AGNJ and UHCCP scored at or above 90% in 13 out of 15 categories for all populations. ABHNJ, HNJH and WCHP scored at or above 90% in 11 out of 15 categories (**Table 18**). WCHP showed the greatest improvement in any category, with a 42 percentage point increase in Preventive Services for the DDD population, followed by a 38 percentage point increase for ABHNJ in Preventive Services for the General Population and a 27 percentage point increase for WCHP in Outreach for the GP. A nine (9) percentage point decrease for AGNJ in Preventive Services for the General Population was the largest decline from 2015 to 2016.

Table 18: Care Management Audit Results

Response by Category	MCO									
	ABHNJ		AGNJ		HNJH		UHCCP		WCHP	
	2015	2016	2015	2016	2015	2016	2015	2016	2015	2016
General Population	n = 100	n = 100	n = 100	n = 100	n = 101	n = 102	n = 101	n = 102	n = 100	n = 98
Identification	61%	74%	85%	92%	85%	89%	90%	92%	56%	80%
Outreach	74%	88%	86%	87%	61%	70%	86%	86%	66%	93%
Preventive Service	29%	67%	88%	79%	96%	100%	92%	87%	50%	65%
Continuity of Care	94%	99%	97%	99%	99%	97%	98%	99%	99%	99%
Coordination of Services	97%	100%	100%	100%	100%	100%	99%	100%	100%	100%
DDD	n = 9	n = 18	n = 50	n = 36	n = 100	n = 100	n = 89	n = 66	n = 21	n = 21
Identification	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%
Outreach	100%	97%	100%	100%	68%	89%	99%	98%	84%	100%
Preventive Service	65%	88%	100%	100%	80%	93%	95%	90%	58%	100%
Continuity of Care	91%	95%	94%	100%	74%	95%	89%	100%	76%	100%
Coordination of Services	100%	100%	99%	100%	91%	98%	99%	99%	93%	100%
DCP&P	n = 15	n = 27	n = 100	n = 100	n = 100	n = 100	n = 100	n = 100	n = 34	n = 20
Identification	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Outreach	82%	100%	99%	100%	83%	86%	100%	99%	85%	87%
Preventive Service	80%	98%	97%	97%	93%	94%	97%	96%	86%	86%
Continuity of Care	100%	100%	95%	100%	81%	99%	100%	100%	90%	95%
Coordination of Services	100%	100%	100%	99%	94%	100%	100%	99%	99%	98%

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

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

ABHNJ

ABHNJ audit results ranged from 67% to 100% across all populations for the five categories.

ABHNJ's compliance rates improved for all categories for the General Population. Although improvement is noted for this population, the rates for two categories remain below 75% (Identification and Preventive Services). Two categories for the DDD population (Preventive Services and Continuity of Care) showed improvement, one category declined slightly (Outreach), and two categories remained the same (Identification and Coordination of Services). The DCP&P population demonstrated improvement for two categories (Outreach and Preventive Services) and three categories (Identification, Continuity of Care and Coordination of Services) remained the same.

Successful outreach, although not considered for scoring purposes, was noted for 52% of the General Population, 61% of the DDD population and 100% of the DCP&P population. Completion of a CNA was evident in 100% of cases reviewed for the General Population and DCP&P, and in 89% of DDD. The rate for development of a timely and complete care plan was 100% for the DCP&P population, followed by 96% for the General Population and 89% for the DDD population. A care plan should be developed for all DDD members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services score was 67% for the General Population, 88% for the DDD population and 98% for the DCP&P population. The 2016 results for the General Population and the DDD population demonstrate significant improvement from last year (from 29% and 65%, respectively). ABHNJ should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable

source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 50% of members in the General Population, 86% in the DDD population and 100% in the DCP&P population. Although improvement is noted for all populations, (from 38% for the General Population, 83% for the DDD population and 89% for the DCP&P population), ABHNJ should ensure that dental needs are addressed for all populations, particularly the General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

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

AGNJ

AGNJ audit results ranged from 79% to 100% across all populations for the five audit categories.

AGNJ's compliance rates improved for three categories for the General Population (Identification, Outreach and Continuity of Care), remained the same for one category (Coordination of Services), and declined slightly for one category (Preventive Services). Three categories for the DDD population (Identification, Outreach and Preventive Services) remained the same at 100%, and two categories showed improvement (Continuity of Care and Coordination of Services). The DCP&P population demonstrated improvement for two categories (Outreach and Continuity of Care); two categories remained the same (Identification and Preventive Services) and one category declined (Coordination of Services).

Successful outreach, although not considered for scoring purposes, was noted for 70% of the General Population, 97% of the DDD population and 97% of the DCP&P population. Completion of a CNA was evident in 100% of cases reviewed for all three populations. The rates of development of a timely and complete care plan increased for all populations from 2015 to 2016; 88% to 95% (General population), 80% to 100% (DDD population), and 87% to 99% (DCP&P population). AGNJ should continue to develop a care plan for all DDD and DCP&P members regardless of whether a member declines care management.

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

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

HNJH

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

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

For the past two audits, the Outreach category was identified as a priority area for improvement efforts. For the General Population, the category of Outreach improved from last year (61% to 70%). The Outreach category showed significant improvement in 2016 for the DDD population (68% to 89%). For the DCP&P population, the Outreach category improved from 83% in 2015 to 86% in 2016.

The rate for initial outreach to complete a CNA improved for the General Population in 2016. Sixty-two percent (62%) of the General Population cases identified as having potential care management needs were noted as receiving timely initial outreach for completion of a CNA (54% in 2015). Similar to prior years, the low rate for timely outreach was largely attributed to untimely outreach to members with newly diagnosed chronic conditions and/or multiple hospitalizations. In most cases, outreach to these members did not occur until March 2017. HNJH should ensure that ongoing methods to analyze member claims, e.g., predictive modeling algorithms, enable early identification of and outreach to established members demonstrating potential care management needs.

For the DDD and DCP&P populations, the rate for initial outreach to complete a CNA improved in 2016. The rate improved from 79% to 99% for the DDD population and from 97% to 100% for the DCP&P population. HNJH should continue to ensure that timely and adequate attempts are made to reach newly enrolled DDD and DCP&P members for completion of the CNA within 45 days of enrollment.

When outreach occurred, successful outreach, although not considered for scoring purposes, was noted for 67% of the General Population, 87% of the DDD population and 97% of the DCP&P population. Completion of a CNA was evident in 100% of cases and 91% of cases included a timely and complete care plan for the General Population. For the DDD population, completion of a CNA was evident in 96% of cases (a significant improvement from 63% in 2015) and 86% of cases included a timely and complete care plan (a significant improvement from 51% in 2015). For the DCP&P population, a CNA was evident in 99% of cases and 96% of cases included a timely and complete care plan; both of these scores demonstrated improvement from 2015. HNJH should continue to develop a care plan for all DDD and DCP&P members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services category showed improvement for all populations. The Preventive Services score for the General Population improved from 96% in 2015 to 100% in 2016. The Preventive Services score was 93% for the DDD population (an increase from 80% in 2015) and 94% for the DCP&P population (an increase from 93% in 2015). HNJH should continue to focus on age-appropriate immunizations for the child and adult populations enrolled in care management as well as the provision of EPSDT exams for the child population. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

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

UHCCP

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

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

Successful outreach, although not considered for scoring purposes, was noted for 84% of the General Population, 77% of the DDD population and 99% of the DCP&P population. A CNA was evident for 100% of cases reviewed for all

populations and 99% of the cases had a timely and complete care plan for the DDD and DCP&P populations, while 98% of cases had a timely and complete care plan for the General Population.

The Preventive Services score for the General Population declined from 92% in 2015 to 87% in 2016. The Preventive Services score was 90% for the DDD population and 96% for the DCP&P population. The child immunization rate declined for the DDD population from 92% to 71% and for the DCP&P population from 97% to 89%. UHCCP should focus on age-appropriate immunizations for the child population enrolled in care management. Confirmation of childhood immunizations from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

The lead screening rate continued to show improvement for the General Population, from 0% in 2014, to 33% in 2015 to 82% in 2016. UHCCP should continue efforts to ensure age-appropriate lead screening. Confirmation of lead screening from a reliable source, such as the PCP, NJ immunization registry, DCP&P nurse should be consistently documented for all populations, as well as attempts to obtain lead status or to provide reminder that a lead screening is due.

Dental needs were addressed for 79% of adult and child members in the General Population, 95% in the DDD population and 98% in the DCP&P population. For the General Population, this rate declined from 95% in 2015. UHCCP should ensure that dental needs are addressed for all populations, particularly the General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

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

WCHP

WCHP audit results ranged from 65% to 100% across all populations for the five audit categories.

WCHP's compliance rates improved for three categories for the General Population (Identification, Outreach and Preventive Services), and remained the same for two categories (Continuity of Care and Coordination of Services). Although improvement is noted for this population, the rate for one category remains below 75% (Preventive Services). Four categories for the DDD population (Outreach, Preventive Services, Continuity of Care, and Coordination of Services) showed improvement and one category remained the same (Identification). All five categories for this population were rated at 100%. The DCP&P population demonstrated improvement for two categories (Outreach and Continuity of Care); two categories (Identification and Preventive Services) remained the same, and one category (Coordination of Services) declined slightly.

Successful outreach, although not considered for scoring purposes, was noted for 67% of the General Population, 76% of the DDD population and 85% of the DCP&P population. Completion of a CNA was evident in 100% of cases reviewed for the General and DDD populations, and 94% for the DCP&P population. Development of timely and complete care plans was evident in 100% of cases reviewed for the General and DDD populations, and for 85% of the DCP&P population. A care plan should be developed for all DDD and DCP&P members regardless of whether a member declines care management services or is unreachable to complete a CNA.

The Preventive Services score was 65% for the General Population, 100% for the DDD population and 86% for the DCP&P population. The 2016 results for the DDD population demonstrate significant improvement (from 58% in 2015). WCHP should focus on age-appropriate immunizations for the child and adult populations enrolled in care management. Confirmation of childhood immunizations and lead screening from a reliable source, such as the PCP, NJ immunization registry, and/or a DCP&P nurse should be consistently documented, including results of lead testing. The care plan and care management notes should address outreach attempts to obtain the status of preventive services and to educate members of the need/benefit of such services.

Dental needs were addressed for 65% of members in the General Population, 100% in the DDD population and 100% in the DCP&P population. Although improvement is noted for the DDD population and DCP&P population (from 64% and 71%, respectively last year), WCHP should continue to ensure that dental needs are addressed for General Population members enrolled in care management, including documentation of the last visit date. The care plan and care management notes should address outreach attempts to obtain the status of dental services and to educate members of the need/benefit of such services.

For the General Population, the category of Outreach improved from 36% in 2014 to 66% in 2015 to 93% in 2016. WCHP should continue to ensure that timely and adequate attempts are made to reach members for completion of the CNA when potential care management needs are identified through completion of the IHS or other sources.

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

2016 MLTSS HCBS Care Management Audits

The purpose of the MLTSS HCBS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to members who met MLTSS eligibility requirements 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 HCBS services by residing in the community or Community Alternative Residential Settings (CARS) within the review period from 7/1/2015 through 6/30/2016. The results from the previous review period (7/1/2014–6/30/2015) were included in the QTR for 2015.This QTR includes the new results from 7/1/2015–6/30/2016.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 30 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of Care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated January 2016. MLTSS PMs #9, #9a, and #16 were added for the review period of 7/1/2015–6/30/16. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. A random sample for each MCO was generated to meet the minimum of 100 records needed for each MCO which included newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/15 and 1/1/16 (Group C) and existing MMC members enrolled in MLTSS between 7/1/15 and 1/1/16 (Group D). If the MCO did not have 100 files, the entire universe was selected for review. Groups A and B from the initial review period were members who were enrolled in the 1915C HCBS waiver for NF level of care prior to July 2014; these groups were not included in the current review period.

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

Performance Measure Results

The statewide PM summary presents a summary based on file review of the MCOs' performance on the following MLTSS PMs: #8 (Initial plan of care established within 30 calendar days of enrollment into MLTSS HCBS), #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS HCBS plans of care that contain a back-up plan, if required), and #16 (Member training on identifying/reporting critical incidents). **Table 19** shows results for the current review period.

Rates were calculated as the number of "Yes" determinations (numerator) divided by the sum of the "Yes" plus "No" determinations (denominator) based on documentation provided for offsite review. Cases scored as "N/A" (not applicable) were not included in the numerator or denominator at the measure level.

Across all plans, the total NJ weighted average for the 7/1/2015–6/30/2016 audit results for both Groups C and D ranged from 44.6% for PM #11 – Plans of care developed using "person-centered principles" to 97.6% for PM #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment.

Table 19: MLTSS Performance Measure Results for 7/1/2015–6/30/2016

Performance Measure	Group	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[1]		
		D	N	Rate	D	N	Rate	D	N	Rate	D	N	Rate	D	N	Rate	D	N	Rate
#8. Initial plan of care established within 30 days of enrollment into MLTSS/HCBS	Group C	68	28	41.2%	57	46	80.7%	46	38	82.6%	76	63	82.9%	13	5	38.5%	260	180	69.2%
	Group D	11	4	36.4%	45	26	57.8%	52	46	88.5%	15	12	80.0%	86	34	39.5%	209	122	58.4%
	Total	79	32	40.5%	102	72	70.6%	98	84	85.7%	91	75	82.4%	99	39	39.4%	469	302	64.4%
#9. Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary	Group C	2	1	50.0%	4	4	100.0%	4	4	100.0%	13	12	92.3%	1	1	100.0%	24	22	91.7%
	Group D	0	0	0.0%	1	1	100.0%	4	3	75.0%	3	3	100.0%	3	3	100.0%	11	10	90.9%
	Total	2	1	50.0%	5	5	100.0%	8	7	87.5%	16	15	93.8%	4	4	100.0%	35	32	91.4%
#9a. Member's plan of care is amended based on change of member condition	Group C	4	0	0.0%	5	4	80.0%	10	6	60.0%	8	4	50.0%	2	0	0.0%	29	14	48.3%
	Group D	3	0	0.0%	6	6	100.0%	6	5	83.3%	2	2	100.0%	8	4	50.0%	25	17	68.0%
	Total	7	0	0.0%	11	10	90.9%	16	11	68.8%	10	6	60.0%	10	4	40.0%	54	31	57.4%
#10. Plans of care are aligned with members needs based on the results of the NJ Choice Assessment	Group C	42	40	95.2%	57	57	100.0%	44	43	97.7%	67	67	100.0%	9	9	100.0%	219	216	98.6%
	Group D	4	3	75.0%	41	40	97.6%	52	49	94.2%	14	13	92.9%	80	79	98.8%	191	184	96.3%
	Total	46	43	93.5%	98	97	99.0%	96	92	95.8%	81	80	98.8%	89	88	98.9%	410	400	97.6%
#11. Plans of care developed using "person-centered principles"	Group C	68	3	4.4%	57	35	61.4%	46	36	78.3%	76	39	51.3%	13	4	30.8%	260	117	45.0%
	Group D	11	1	9.1%	45	18	40.0%	52	36	69.2%	15	9	60.0%	86	28	32.6%	209	92	44.0%
	Total	79	4	5.1%	102	53	52.0%	98	72	73.5%	91	48	52.7%	99	32	32.3%	469	209	44.6%
#12. MLTSS Home and Community-Based Services (HCBS) plans of care that contain a back-up plan[2]	Group C	48	17	35.4%	29	25	86.2%	22	19	86.4%	37	33	89.2%	10	7	70.0%	146	101	69.2%
	Group D	8	1	12.5%	39	32	82.1%	47	44	93.6%	14	13	92.9%	75	65	86.7%	183	155	84.7%
	Total	56	18	32.1%	68	57	83.8%	69	63	91.3%	51	46	90.2%	85	72	84.7%	329	256	77.8%
#16. Member training on identifying/reporting critical incidents	Group C	68	7	10.3%	57	57	100.0%	46	44	95.7%	76	68	89.5%	13	0	0.0%	260	176	67.7%
	Group D	11	0	0.0%	45	44	97.8%	52	46	88.5%	15	13	86.7%	86	1	1.2%	209	104	49.8%
	Total	79	7	8.9%	102	101	99.0%	98	90	91.8%	91	81	89.0%	99	1	1.0%	469	280	59.7%

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

[2] Members in Community Alternative Residential Setting (CARS) are excluded from this measure.

Group C: members new to Managed Care and newly eligible to MLTSS; Group D: current members newly enrolled to MLTSS; D: denominator; N: numerator.

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

ABHNJ

Total results of ABHNJ's 7/1/2015–6/30/2016 MLTSS PMs ranged from 0.0% for #9a (Member's plan of care is amended based on change of member condition) to 93.5% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. All MLTSS performance rates fell below 85% with the exception of PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment). It should be noted that this was the MCO's first MLTSS HCBS CM audit.

Issues were identified regarding the lack of documentation within CM files, and the MCO acknowledged system limitations as a root cause of some of these issues. The MCO needed to provide documentation to show that the initial plans of care were developed using person-centered principles, completed, signed and given to the member and/or representative in a timely manner. As part of ongoing CM, plans of care should be updated based on change in member condition, signed and a copy should be provided to the member and/or authorized representative. Based on the results of the audit, the MCO received a corrective action plan (CAP).

AGNJ

Total results of AGNJ's 7/1/2015–6/30/2016 MLTSS PMs ranged from 52.0% for #11 (Plans of care developed using "person-centered principles") to 100.0% for #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary) in the review period. The MCO fell below 85% in three (3) of the seven (7) PMs, namely, #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #11 (Plans of care developed using "person-centered principles") and #12 (Plans of care contain a back-up plan).

Issues related to the consistency of report dates, member and/or representative electronic signature dates, and other supporting information within the care management files were identified during the audit. In addition, the MCO experienced issues regarding the implementation of person-centered principles in the development of a plan of care, and providing a copy to the member and/or representative in a timely manner. Based on the results of the audit, the MCO received a CAP.

HNJH

Total results of HNJH's 7/1/2015–6/30/2016 MLTSS PMs ranged from 68.8% for #9a (Member's plan of care is amended based on change of member condition) to 95.8% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. The MCO fell below 85% in two (2) of the seven (7) PMs, namely, #9a (Member's plan of care is amended based on change of member condition) and #11 (Plans of care developed using "person-centered principles").

Issues identified during the audit were related to the Cost Effectiveness Evaluation Form. The MCO reported a system limitation enabling the auditor to only view the most current evaluation that was present in the member's MLTSS care management file at the time the file was printed for review. In addition, plans of care should be developed using person-centered principles. As part of ongoing care management, plans of care should be updated based on change in member condition, signed and a copy provided to the member and/or authorized representative. Based on the results of the audit, the MCO received a CAP.

UHCCP

Total results of UHCCP's 7/1/2015–6/30/2016 MLTSS PMs ranged from 52.7% for #11 (Plans of care developed using "person-centered principles") to 98.8% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. The MCO fell below 85% in three (3) of the seven (7) PMs, namely, #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9a (Member's plan of care is amended based on change of member condition) and #11 (Plans of care developed using "person-centered principles").

Documentation issues were identified during the audit. The MCO needed to ensure that plans of care were developed using person-centered principles, completed, signed with a copy provided to the member and/or representative in a timely manner. This included members identified as cognitively impaired since a signature must be obtained from an authorized representative. Plans of care also needed to reflect updates as the member's condition changes. In addition, documentation needed to show if the member and/or representative was in agreement or disagreement with the plan of care, including any changes made to the plan of care based on the member's needs. Based on the results of the audit, the MCO received a CAP.

WCHP

Total results of WCHP's 7/1/2015–6/30/2016 MLTSS PMs ranged from 1.0% for #16 (Member training on identifying/reporting critical incidents) to 100.0% for #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary) in the review period. The MCO fell below 85% in four (4) of the seven (7) PMs, namely, 8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #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).

The MCO experienced some issues in file preparation for the audit. The MCO did not initially present complete single files for each member for review with all of documentation required for review. In addition, the MCO should ensure person-centered principles in the development of a plan of care, and providing a copy to the member and/or representative in a timely manner. As part of ongoing CM, plans of care should be updated based on change in member condition, signed and a copy should be provided to the member and/or authorized representative. Documentation should show that members and/or authorized representatives are trained on the identification and reporting of critical incidents. Based on the results of the audit, the MCO received a CAP.

2017 MLTSS HCBS Care Management Audits

The purpose of the annual MLTSS HCBS CM audit was to continue to evaluate the effectiveness of the contractually required MLTSS CM programs of ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or CARS within the review period from 7/1/2016 through 6/30/2017. The results from the previous review period (7/1/2015–6/30/2016) were compared to the 2017 audit, which includes the new results from 7/1/2016–6/30/2017.

IPRO prepared an audit tool structured to collect requirement-specific information related to: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care/Critical Incidents in addition to required MLTSS PMs (#8 – Initial plan of care established within 30 calendar days of enrollment into MLTSS HCBS; #9 – Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary; #9a – Member's plan of care is amended based on change of member condition; #10 – Plans of care are aligned with member needs based on the results of the NJ Choice Assessment; #11 – Plans of care developed using "person-centered principles"; #12 – MLTSS HCBS plans of care that contain a back-up plan, if required; and #16 – Member training on identifying/reporting critical incidents). The audit tool was based on the DMAHS MCO Contract (Article 9) dated July 2016. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data. Enrollees permanently residing in an NF were removed. In addition to newly eligible MLTSS cases for the review enrolled with the MCOs between 7/1/16 and 1/1/17(Group C) and existing MMC members enrolled in MLTSS between 7/1/16 and 1/1/17 (Group D), the 2017 audit included a new subgroup (Group E) for current MMC members who were enrolled in MLTSS prior to the start of the review period (7/1/2016) and continuously enrolled with the MCO in MLTSS through 6/30/17. A stratified methodology was used to randomly select 75 HCBS MLTSS members across subgroups C and D, and 25 HCBS MLTSS members in subgroup E as a base sample. A 10% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions. All HCBS MLTSS members were included if there were less than 75 members across subgroups C and D, or less than 25

members in subgroup E; however, a minimum of 100 files were to be reviewed and abstracted across all three groups. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files.

In order to achieve a denominator of 100 members for MLTSS Performance Measure #8 (Plans of Care established with the required timeframe), an additional ancillary group of 25 HCBS MLTSS members were randomly selected and abstracted from subgroups C and D.

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

Performance Measure Results

Table 20 presents a summary based on file review of the MCOs' performance for the following MLTSS PMs: #8 (Initial plan of care established within 30 calendar days of enrollment into MLTSS HCBS), #9 (Member's plan of care is reviewed annually within 30 days of members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS HCBS plans of care that contain a back-up plan, if required), and #16 (Member training on identifying/reporting critical incidents). Results were compared from the prior review period (7/1/2015 to 6/30/2016) to the current review period (7/1/2016 to 6/30/2017) for Groups C and D. Results for Group E will be used as baseline rates as applicable.

There were some changes made in the current review period (7/1/2016 to 6/30/2017). The methodology was revised for PMs #8, #11 and #12. Due to a change in the MCO contract with DMAHS (July 2016), MCOs were responsible for obtaining a copy of the existing assessment of conducting a NJ Choice Assessment (NJCA) system, completing the initial face-to-face visit and completing the plan of care, including the member's signature, within 45 calendar days of enrollment notification. As a result, compliance with PM #8 was calculated using 45 calendar days to establish an initial plan of care. 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. For PM #12, members permanently residing in a community alternative residential setting were excluded in all review periods. For the remaining members living in the community, back-up plans were required to assure that needed assistance would be provided in the event that regular services and supports identified in the plans of care became temporarily unavailable, and the plan was for the member to remain in the home.

Rates were calculated as the number of "Yes" determinations (numerator) divided by the sum of the "Yes" plus "No" determinations (denominator) based on documentation provided for offsite review. Cases scored as "N/A" (not applicable) were not included in the numerator or denominator at the measure level.

Across all plans, the total NJ weighted average for the 7/1/2016–6/30/2017 audit results for Groups C, D and E ranged from 37.7% for PM #9a -Member's plan of care is amended based on change of member condition to 84.0% for PM #10 - Plans of care are aligned with member needs based on the results of the NJ Choice Assessment.

Table 20: Comparison of Performance Measures: Both Review Periods

Performance Measure[1]	Group	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[2]		
		7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD
#8. Initial plan of care established within 30 days of enrollment into MLTSS/HCBS[3]	C	41.2	30.5	-10.7	80.7	88.4	7.7	82.6	87.2	4.6	82.9	87.2	4.3	38.5	90.0	51.5	69.2	72.9	3.7
	D	36.4	24.4	-12	57.8	80.7	22.9	88.5	83.6	-4.9	80.0	86.4	6.4	39.5	84.4	44.9	58.4	74.5	16.1
	E																		
	TOTAL	40.5	28.0	-12.5	70.6	84.0	13.4	85.7	85.0	-0.7	82.4	87.0	4.6	39.4	85.0	45.6	64.4	73.8	9.4
#9. Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary[4]	C	50.0	100.0	50	100.0	75.0	-25	100.0	100.0	0	92.3	N/A	N/A	100.0	N/A	N/A	91.7	85.7	-6.0
	D	0.0	N/A	N/A	100.0	66.7	-33.3	75.0	77.8	2.8	100.0	N/A	N/A	100.0	75.0	-25	90.9	63.2	-27.7
	E		50.0			84.6			94.1			83.3			75.0			83.3	
	TOTAL	50.0	44.4	-5.6	100.0	80.0	-20	87.5	88.9	1.4	93.8	83.3	-10.5	100.0	75.0	-25	91.4	78.4	-13.0
#9a. Member's plan of care is amended based on change of member condition[5]	C	0.0	N/A	N/A	80.0	100.0	20	60.0	100.0	40	50.0	75.0	25	0.0	50.0	50	48.3	73.3	25.0
	D	0.0	N/A	N/A	100.0	50.0	-50	83.3	62.5	-20.8	100.0	0.0	-100	50.0	0.0	-50	68.0	30.0	-38.0
	E		25.0			0.0			100.0			0.0			0.0			16.7	
	TOTAL	0.0	14.3	14.3	90.9	30.0	-60.9	68.8	80.0	11.2	60.0	42.9	-17.1	40.0	7.1	-32.9	57.4	37.7	-19.7
#10. Plans of care are aligned with members needs based on the results of the NJ Choice Assessment[6]	C	95.2	52.2	-43.0	100.0	97.4	-2.6	97.7	93.5	-4.2	100.0	85.7	-14.3	100.0	85.7	-14.3	98.6	81.1	-17.5
	D	75.0	65.7	-9.3	97.6	90.9	-6.7	94.2	92.0	-2.2	92.9	94.7	1.8	98.8	92.0	-6.8	96.3	87.9	-8.4
	E		52.6			88.9			88.9			100.0			72.2			80.2	
	TOTAL	93.5	57.0	-36.5	99.0	93.0	-6	95.8	91.9	-3.9	98.8	90.0	-8.8	98.9	88.0	-10.9	97.6	84.0	-13.6
#11. Plans of care developed using "person-centered principles"[7]	C	4.4	45.7	41.3	61.4	57.9	-3.5	78.3	83.9	5.6	51.3	73.0	21.7	30.8	85.7	54.9	45.0	65.4	20.4
	D	9.1	54.3	45.2	40.0	61.4	21.4	69.2	76.0	6.8	60.0	84.2	24.2	32.6	66.7	34.1	44.0	67.3	23.3
	E		47.4			100.0			61.1			50.0			72.2			65.9	
	TOTAL	5.1	49.0	43.9	52.0	67.0	15	73.5	75.8	2.3	52.7	71.0	18.3	32.3	69.0	36.7	44.6	66.3	21.7
#12. MLTSS Home and Community-Based Services	C	35.4	54.8	19.4	86.2	38.1	-48.1	86.4	100.0	13.6	89.2	75.8	-13.4	70.0	40.0	-30	69.2	67.2	-2.0
	D	12.5	42.9	30.4	82.1	52.4	-29.7	93.6	93.5	-0.1	92.9	92.9	0	86.7	75.7	-11	84.7	70.6	-14.1

Performance Measure[1]	Group	ABHNJ			AGNJ			HNJH			UHCCP			WCHP			NJ Weighted Average[2]		
		7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD	7/15 to 6/16	7/16 to 6/17	PPD
(HCBS) plans of care that contain a back-up plan[8]	E		68.8			26.7			100.0			76.9			72.2			66.7	
	TOTAL	32.1	52.4	20.3	83.8	43.6	-40.2	91.3	96.3	5	90.2	80.0	-10.2	84.7	73.2	-11.5	77.8	68.9	-8.9
#16. Member training on identifying/reporting critical incidents	C	10.3	58.7	48.4	100.0	86.8	-13.2	95.7	93.5	-2.2	89.5	79.4	-10.1	0.0	14.3	14.3	67.7	75.7	8.0
	D	0.0	57.1	57.1	97.8	84.1	-13.7	88.5	92.0	3.5	86.7	89.5	2.8	1.2	6.7	5.5	49.8	56.1	6.3
	E		84.2			100.0			88.9			94.4			11.1			75.8	
	TOTAL	8.9	63.0	54.1	99.0	88.0	-11	91.8	91.9	0.1	89.0	84.0	-5	1.0	8.0	7	59.7	66.9	7.2

[1] The units are percentage points.

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

[3] From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.

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

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

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

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

[8] Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017. In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing.

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; PPD: percentage point difference between the prior year and the current year.

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

ABHNJ

Total results of ABHNJ's 7/1/2016–6/30/2017 MLTSS PMs ranged from 14.3% for #9a (Member's plan of care is amended based on change of member condition) to 63.0% for #16 (Member training on identifying/reporting critical incidents) in the review period. Based on all subgroups combined, all MLTSS performance rates fell below 85%.

Documentation issues revealed the MCO's need to ensure initial plans of care are completed and signed in a timely manner, and developed using "person-centered" principles. Back-up plans should be included in the file, reviewed and signed on a quarterly basis as appropriate. As part of the ongoing CM process, member care plans should be completed within 30 calendar days of the member's anniversary (from the date of the initial plan of care or most recent revised care plan) and amended according to changes in the members' condition, including but not limited to, facility discharges. File documentation should address training a member and/or representative on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation. Based on the results of the audit, the MCO received a CAP.

AGNJ

Total results of AGNJ's 7/1/2016–6/30/2017 MLTSS PMs ranged from 30.0% #9a (Member's plan of care is amended based on change of member condition) to 93.0% for #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment) in the review period. Based on all subgroups combined, the MCO scored above 85% in two (2) of the seven (7) PMs, namely, #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment) and #16 (Member training on identifying/reporting critical incidents). The remaining five (5) PMs fell below 85%; #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles") and #12 (MLTSS plans of care that contain a back-up plan).

The MCO experienced some issues in file preparation for the audit. The MCO revised its audit procedures from presenting paper files for review to electronic files. In file preparation, the MCO presented some files that were incomplete and lacking signed documents such as the interim plans of care, initial plans of care and back-up plans. The MCO should show evidence that initial plans of care are established in a timely manner. The MCO should ensure completed and signed plans of care and back-up plans are on file. Documentation should reflect a member-centric approach demonstrating member involvement in the development and modification to the agreed-upon goals, informal and formal supports, and that options counseling is conducted on every member. As part of ongoing CM, the MCO should ensure that annual care plans are clearly identified and completed within 30 calendar days of the member's anniversary (from the date of the initial plan of care or most recent revised plan of care), and care plans are amended based on changes in member condition, including but not limited to, facility discharges. Based on the results of the audit, the MCO received a CAP.

HNJH

Total results of HNJH's 7/1/2016–6/30/2017 MLTSS PMs ranged from 75.8% for #11(Plans of care developed using "person-centered principles") to 96.3% for #12 (MLTSS plans of care that contain a back-up plan) in the review period. Based on all the subgroups combined, the MCO scored 85% or above in five (5) of the seven (7) PMs, namely, #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment), #12 (MLTSS plans of care that contain a back-up plan)and #16 (Member training on identifying/reporting critical incidents). The remaining two (2) PMs fell below 85%; #9a (Member's plan of care is amended based on change of member condition) and #11 (Plans of care developed using "person-centered principles").

Issues identified were related to documentation to show evidence that options counseling is conducted on every member, and the plans of care provided to the member and/or authorized representative addresses the member's goals, as well as, any formal and informal support services. In addition, plans of care should be amended based on the member's condition, including but not limited to, facility discharges. Based on the results of the audit, the MCO received a CAP.

UHCCP

Total results of UHCCP's 7/1/2016–6/30/2017 MLTSS PMs ranged from 42.9% for #9a (Member's plan of care is amended based on change of member condition) to 90.0% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. Based on all the subgroups combined, the MCO scored above 85% in two (2) of the seven (7) PMs, namely, #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS) and #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment). The remaining five (5) PMs fell below 85%; #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS plans of care that contain a back-up plan) and #16 (Member training on identifying/reporting critical incidents). Based on the results of the audit, the MCO received a CAP.

Documentation issues were identified to show evidence of "person-centered principles". The MCO needs to ensure that options counseling was conducted on every member, and that the plans of care provided to the member and/or authorized representative addresses the member's goals and issues identified during the assessment and care planning process, as well as, any formal and informal support services. The MCO should review their internal process to ensure back-up plans are developed to address needed assistance in the event that regular services and supports identified in the plan of care become temporarily unavailable so that the member can remain in his/her home. File documentation should include member training on identifying and reporting critical incidents as appropriate. As part of ongoing CM, the MCO should ensure that annual care plans are clearly identified and completed within 30 calendar days of the member's anniversary (from the date of the initial plan of care or most recent revised plan of care), and member care plans are amended based on the member's condition, including but not limited to, facility discharges. Based on the results of the audit, the MCO received a CAP.

WCHP

Total results of WCHP's 7/1/2016–6/30/2017 MLTSS PMs ranged from 7.1% for #9a (Member's plan of care is amended based on change of member condition) to 88.0% for #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) in the review period. Based on all the subgroups combined, the MCO scored 85% or above in two (2) of the seven (7) PMs, namely, #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS) and #10 (Plans of care are aligned with member needs based on the results of the NJ Choice Assessment).

The MCO fell below 85% in the remaining five (5) PMs: #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles"), #12 (MLTSS plans of care that contain a back-up plan), and #16 (Member training on identifying/reporting critical incidents).

Documentation issues were identified for the review period. As part of "person-centered principles", the MCO needs to ensure that options counseling is conducted on every member, and that the plans of care provided to the member and/or authorized representative addresses the member's goals and issues identified during the assessment and care planning process, as well as, any formal and informal support services. The MCO should review their internal process to ensure back-up plans are developed to address needed assistance in the event that regular services and supports identified in the plan of care become temporarily unavailable so that the member can remain in his/her home. File documentation should include member training on identifying and reporting critical incidents as appropriate. As part of ongoing CM, the MCO should ensure that annual care plans are clearly identified and completed within 30 calendar days of the member's anniversary (from the date of the initial plan of care or most recent revised plan of care), and member

care plans are amended based on the member's condition, including but not limited to, facility discharges. Based on the results of the audit, the MCO received a CAP.

2016 MLTSS Nursing Facility Care Management Audits

The purpose of the MLTSS NF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM programs at ABHNJ, AGNJ, HNJH, UHCCP, and WCHP. The audit addressed MCO contract requirements for monitoring performance based on the MCO Contract, (Article 9) from the State of New Jersey DHS, DMAHS MCO Contract to provide services dated July 2015. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in an NF or SCNF for at least six consecutive months within the review period from 7/1/2015 through 6/30/2016.

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Transition Plan and Contract references. 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 the NF/SCNF. The MCO reports contained the findings of IPRO's audit including the MLTSS PMs, and were presented in five sections: Introduction, Methodology, Audit Results, Limitations, and Conclusions and Recommendations.

Assessment Methodology

IPRO identified the specific populations using eligibility data using capitation codes to identify MLTSS HCBS and NF/SCNF enrollment. A random sample for each MCO was generated to meet the minimum of 100 records needed for each MCO which included MLTSS members permanently residing in NF/SCNF between 7/1/2015 through 6/30/ 2016 (Group 1), MLTSS members residing in an NF/SCNF for at least six consecutive months between 7/1/2015 and 6/30/2016 and transitioned to HCBS for at least one month during the review period (Group 2), MLTSS members residing in HCBS for at least one month and transitioned to an NF/SCNF for at least six consecutive months during the review period (and still residing in the NF/SCNF) at the end of the review period (Group 3), and MLTSS members residing in HCBS for at least one month, transitioned to an NF/SCNF for at least six consecutive months, and transitioned back to HCBS for at least one month during the review period (Group 4). Members residing in an NF/SCNF less than six consecutive months at any time between 7/1/2015 and 6/30/2016 were excluded from the study. If the MCO did not have 100 files, the entire universe was selected for review.

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

Summary of Results

Table 21 displays MCO results based on care management file review for the period of 7/1/2015-6/30/2016. The reported rates include members from Group 1 (members permanently residing in an NF/SCNF throughout the entire review period), Group 2 (members who transitioned from an NF/SCNF to HCBS) and Group 3 (members who transitioned from HCBS to the NF/SCNF). Results were limited due to the low volume of members identified in Groups 2 and 3. AGNJ was the only MCO that had members identified in Groups 1, 2, and 3. Based on file review, none of the MCOs had Members identified in Group 4 (members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period.

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

Across all five MCOs in the category Plan of Care for Institutional Settings, all five MCOs scored above 85% for having a supplemental plan of care on file and demonstrating coordination of care (**Table 21**). Four of the five MCOs scored above 90% for having the member present and included in onsite visits by the care manager. All five MCOs have an opportunity for improvement to include copies of facility plans of care in the MCO care management file,

documentation of review of the facility's plan of care, participation in facility IDT meetings and timely onsite review for member placement and services.

Four MCOs had members that fell in the category of HCBS Members Transferred to an NF/SCNF. There were no review elements that scored above 85% across these four MCOs. Two of the four MCOs scored above 85% for having a New Jersey Choice Assessment Completed to Reassess a Member for Transfer to an NF/SCNF. It was noted that one MCO scored above 85% in 5 of the 14 review elements, one MCO scored above 85% in 2 of the 14 review elements and one MCO in 1 of the 14 review elements; however, caution should be taken during the interpretation of these results due to the low number of care management records reviewed for some of the elements. All four MCOs have an opportunity for improvement in IDT meeting attendance pertaining to member transfer to an NF/SCNF, amending the plans of care as appropriate, and including a completed PASRR Level I or Level II (if applicable) prior to transfer to an NF/SCNF on file.

Only two MCOs had members that fell in the category of NF/SCNF Member Transferred to HCBS. As a result, a comparison could not be made across MCOs.

Table 21: MLTSS NF Care Management Results for 7/1/2015–6/30/2016

Category	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	2016 Total Rates														
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Plan of Care for Institutional Settings															
Copies of Facility Plans of Care on File	2	67	3.0%	74	100	74.0%	40	100	40.0%	31	100	31.0%	24	96	25.0%
Documented Review of a Facility Plan of Care	14	67	20.9%	63	100	63.0%	82	100	82.0%	68	100	68.0%	30	96	31.3%
Supplemental Plan of Care on File	50	54	92.6%	68	70	97.1%	81	90	90.0%	86	96	89.6%	77	84	91.7%
Participation in Facility IDT Meetings	2	65	3.1%	7	89	7.9%	29	91	31.9%	0	93	0.0%	9	91	9.9%
Timely Onsite Review of Member Placement and Services	16	67	23.9%	45	100	45.0%	49	100	49.0%	40	100	40.0%	9	96	9.4%
Member Present and Included in Onsite Visits	54	58	93.1%	89	96	92.7%	93	99	93.9%	88	93	94.6%	58	72	80.6%
Coordination of Care	62	67	92.5%	93	100	93.0%	93	100	93.0%	89	100	89.0%	88	96	91.7%
NF/SCNF Member Transferred to HCBS															
Identification of Member for Transfer to HCBS	1	2	50.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
NJCA Completed Prior to Discharge from a Facility	1	2	50.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cost Effectiveness Evaluation Completed Prior to Discharge from a Facility	0	2	0.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Plan of Care Prior to Discharge from a Facility	1	2	50.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Person-Centered Transition Plan of Care on File	1	2	50.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Participation in an IDT related to Transition	2	2	100.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Authorization and Procurement of Transitional Services	1	2	50.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Services Initiated upon Facility Discharge according to Plan of Care	2	2	100.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Face-to-Face Visit within 10 business days following a Facility Discharge to the Community	0	2	0.0%	0	1	0.0%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HCBS Members Transferred to an NF/SCNF															
NJCA Completed to Reassess Member	N/A	N/A	N/A	10	10	100.0%	8	9	88.9%	3	7	42.9%	1	5	20.0%
Cost Effectiveness Evaluation Completed to Address NF/SCNF Placement	N/A	N/A	N/A	1	10	10.0%	8	9	88.9%	0	7	0.0%	0	5	0.0%
Care Manager Initiated an IDT	N/A	N/A	N/A	1	3	33.3%	1	1	100.0%	0	4	0.0%	0	0	N/A
IDT occurred at Member's Place of Residence	N/A	N/A	N/A	2	2	100.0%	0	1	0.0%	0	0	N/A	0	0	N/A
IDT Attendance	N/A	N/A	N/A	1	2	50.0%	0	1	0.0%	0	0	N/A	0	0	N/A
Member Advised Prior to the IDT	N/A	N/A	N/A	0	2	0.0%	1	1	100.0%	0	0	N/A	0	0	N/A

Category	ABHNJ			AGNJ			HNJH			UHCCP			WCHP		
	2016 Total Rates														
	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate	N	D	Rate
Expedited IDT Review within 3 business days of a Request	N/A	N/A	N/A	0	1	0.0%	0	0	N/A	0	0	N/A	0	0	N/A
Member Provided Opportunity to Select HCBS and Enter a Risk Management Agreement	N/A	N/A	N/A	4	5	80.0%	1	1	100.0%	0	4	0.0%	0	1	0.0%
Documentation of Discussion with the Member prior to Change of Service/Placement	N/A	N/A	N/A	0	2	0.0%	0	0	N/A	0	2	0.0%	0	0	N/A
Amended Plan of Care as Appropriate	N/A	N/A	N/A	7	10	70.0%	5	8	62.5%	3	4	75.0%	0	3	0.0%
Completion of PASRR Level I and Level II, if applicable, prior to Transfer to an NF/SCNF	N/A	N/A	N/A	6	10	60.0%	6	9	66.7%	5	7	71.4%	2	5	40.0%
Communication of PASRR Level I	N/A	N/A	N/A	8	10	80.0%	7	9	77.8%	6	7	85.7%	3	5	60.0%
Communication of PASRR Level II	N/A	N/A	N/A	0	0	N/A	0	1	0.0%	0	0	N/A	0	0	N/A
Care Manager Explains Any Payment Liability	N/A	N/A	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A

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

CHAPTER 4 – FOLLOW-UP TO QTR RECOMMENDATIONS FROM CONTRACT YEAR 5

The BBA, Section 42 CFR section 438.364(a)(5), states that the EQRO (IPRO) "must provide an assessment of the degree to which each MCO has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR." IPRO requested that each MCO describe how its organization addressed MCO-specific recommendations from the IPRO CY 5 QTR. The following is a summary of how the MCOs addressed the recommendations.

ABHNJ

ABHNJ addressed IPRO's CY 5 QTR recommendations as follows:

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

Aetna Better Health of New Jersey is committed to improving our members' health outcomes, enhancing their quality of life and reducing racial and ethnic health disparities by providing "effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health believes and practices, preferred languages, health literacy, and other communication needs"[5]. To achieve these goals we have implement a Cultural Competency work plan, based on the enhanced National Culturally and Linguistically Appropriate Services (CLAS) standards. The work plan will include:

- Training, programs and processes to develop and maintain a culturally competent staff and provider network
- Activities aimed at identifying and analyzing the health and health care disparities that are creating barriers to healthy living for our members
- A plan that addresses how Aetna Better Health of New Jersey will engage and build the provider network to be responsive to identified needs and barriers

This comprehensive Cultural Competency plan will encompass strategies designed to assist staff, providers and subcontractors with integrating cultural and linguistic competency with health literacy into every aspect of operations, including marketing, community outreach and education programs. The plan is a guide to the actions Aetna Better Health of New Jersey will implement to promote an understanding of and respect for the diverse cultural backgrounds, attitudes, and beliefs of our service population.

As a first step towards implementing a plan specific Cultural Competency Program, the plan completed a Population Assessment on June 27, 2016, based on 2016 membership. The information collected in this assessment will be utilized to identify potential disparities in the services provided by sub-populations. This analysis will then be used to develop and implement action plans to address these disparities to ensure all members have access to and are receiving the same level and quality of care.

Some areas that will be examined include:

- Variations between authorized and denied services
- Variations surrounding services being requested

Comparing specific HEDIS scores (i.e. Diabetes) among different populations and members with differing services codes; i.e. DDD vs. ABD vs. Medicaid expansion.

[5] U.S. Department of Health and Human Services, Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*.

- *The plan should show evidence that an MLTSS Consumer Advisory Committee and Dental Affairs Advisory Committee has been established and is meeting on a regular basis.*

The MLTSS Consumer Advisory Committee was formed and met 4 times during the 2016-2017 Fiscal Year, on the following dates: 6/29/16, 12/22/16, 3/30/17 and 6/28/17. The two initial meetings were joint meetings with the Member Advisory Committee and had low attendance. For 2017, the plan for the MLTSS meeting was altered to develop an individual meeting dedicated to MLTSS and a new orientation toward embedding the meetings in the community; this approach was more successful in achieving significant member attendance.

Planning and execution of the MLTSS Consumer Advisory included selection of a strategic location for each meeting (such as one that serves food) in the communities we serve, making member attendance much easier. The locations will change for each meeting so that we can be sure members from each of our different communities are able to attend (north, central and south). We partnered with our vendors to assist us in boosting member attendance, i.e. a Medical Day Care vendor who attended and transported multiple members at once. This successful strategy will be continued for all meetings in the foreseeable future. The agenda promoted an interactive experience for the plan and the members during which brief snapshots of different functions within the organization were provided, including care management, dental services, quality, member services, wellness and educational programs. Members were encouraged to provide their perspective and their suggestions for how the plan can improve our services to make them easier to access and understand by the members. Member feedback and suggestions were taken back to the plan and will be incorporated into our program efforts. The meetings were 90 minutes in length. More than seven members and providers attended each meeting.

The Dental Advisory Committee was formed and met 4 times during the 2016-2017 Fiscal Year. Those dates were: 10/31/16, 12/19/16, 2/07/17 and 5/31/17. The Dental Advisory Committee membership includes three external dental providers as well as the plan Dental Director and an Aetna nationally based Dental provider. All of the external providers focus on dental care to individuals with special needs. Topics discussed included Quality as it relates to dental access and care, member education, grievances and appeals; educational material was presented to support these topics.

- *The plan should continue to recruit for their dental network to address the deficiency in Somerset County.*

Aetna Better Health of New Jersey has been meeting monthly with our dental vendor, DentaQuest, to discuss how to increase access in Somerset County. All dentists in Somerset County for whom there was an indication of potential participation (such as membership in another MCO) were identified and contacted by our vendor; in some cases direct contact was initiated by the Aetna Better Health Dental Director. Aggressive contracting was undertaken and included site visits by representatives of DentaQuest and multiple specialized contracts that included enhanced fees, a specific strategy for Somerset County. As a result of specialized contracting, more dentists joined the network. Somerset County is 92.20% compliant for access as of May 17, 2017.

- *The plan should identify and develop staff with regards to QIP development and implementation.*

The Quality Department at Aetna Better Health of New Jersey has new staff with relevant quality expertise. In April 2017, the plan's current QIP on Falls Prevention was transitioned to a new newly created MLTSS Quality Liaison, reporting to the Director of Quality Management. The MFP Liaison role was filled by Susan Ruddiman, RN, whose background and experience include 8 years in a managed Medicaid environment in New Jersey, experience managing staff and processes related to various types of care and case management, assisting in the transition of State Plan services to the MCOs in 2011, and planning and implementation of Long Term Services and Supports in 2013-2014. As Manager of MLTSS for Aetna Better Health, Susan collaborated with Quality Management in implementation of the QIP. This included the development of the algorithm that staff uses to implement their day-to-day process flow for MLTSS members who experienced a fall. The project involves collaboration with the MLTSS Manager, Quality Director, and Informatics team to present the data and outcomes related to QIP interventions.

A new QIP will be initiated in the fall of 2017. Assigned to that project will be Mary Lou Christopher, RN. Mary Lou has 25 yrs. of experience in Health Care Quality Management in various settings; she holds a designation as a Certified Professional in Healthcare Quality (CPHQ); she has also worked on numerous Collaborative Projects with Federal, State and County agencies. She has served as the Director of QM at RWJ Barnabas Health System, and has also served as a past Board member of the HQPNJ organization (Healthcare Quality Professionals of New Jersey). Mary Lou joined Aetna Better Health of New Jersey in January, 2017 as a Quality Management Consultant.

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

The Quality Department has increased its focus on assurance that members receive medically appropriate primary care services. The increase in staff has been accompanied by more organized efforts to inform and educate members and families about these services. EPSDT mailers which include information regarding immunizations and medical visits by age are mailed to each member household during the birthday month of the child. Additionally, the Aetna employees that support member services, care management and quality management have access to a number of tools to identify gaps in care. Every contact with a member is considered an opportunity to discuss gaps in care; this includes contacts such as inbound calls by members to Member Services, both inbound and outbound contacts with care management and through direct member outreach. Pediatric and other related provider types are provided with monthly reports that identify members within their panel who have gaps in care (posted on the Provider Portal). On a quarterly basis, member newsletters are published and sent to members; these always include topics related to EPSDT screening. Ongoing provider education is available via provider newsletters and with information placed on the provider portal. National guidelines related to primary care, including immunization schedules and components of well child care, are posted in the Provider section of the public website.

All members in DDD are in care management, as are all children in DCP&P. The care managers monitor their access to and utilization of health maintenance services; and provide guidance and assistance in access when needed. Health maintenance information regarding last dental checkup is included in the regularly monitored information.

The plan is poised to "go live" with a dental home program that will target our youngest members, aged 0 to 6. This program will engage children from infancy to school age years for the purpose of initiating early, ongoing and consistent dental care. The plan is optimistic that a collateral effect of this program will be the engagement of older siblings in dental care as all family members will be able to access a single provider site. Documentation of last dental visit information is provided to the plan through the claims data. Aetna is working with our dental vendor, DentaQuest, to initiate an outreach program that will contact *all* members to encourage the annual dental visit as well as assisting the members in setting up an appointment with a conveniently located dentist.

The Dental Home program will be implemented as soon as the plan receives final approval from the State on member materials related to this program.

- *The plan should ensure timely outreach and a minimum of two different methods of outreach to complete an Initial Health Screen (IHS) for newly enrolled General Population members. In addition, the plan should ensure that timely and adequate attempts are made to reach members of the General Population for completion of the Complex Needs Assessment (CNA) when potential care management needs are identified through completion of the IHS or other sources.*

Aetna Better Health of New Jersey has a process in place to ensure that all general population members who are newly enrolled have outreach for the Initial Health Screening (I.H.S.) within 45 days of eligibility. This timeframe is monitored and processed through our care management system. We are also researching adding resources by examining the use of vendor to back-up our I.H.S. calls, with oversight by our Medical Management Department.

Multiple attempts to contact these members include an initial telephonic outreach and, for unsuccessful contact, an unable-to-contact letter is sent. Additional telephonic outreach attempts are performed at various times of the day to enhance a positive contact. There are a minimum of three contacts. All members that have an I.H.S. score of 5 or above and any member with potential care management needs is contacted for further outreach and offered care management. Any member that opts into care management is then contacted by a licensed care manager for the Comprehensive Needs Assessment within 30 days of I.H.S. completion.

AGNJ

AGNJ addressed IPRO's CY 5 QTR recommendations as follows:

- *The plan should evaluate healthcare disparities for its population using data such as claims and eligibility data, undertake barrier analysis, and develop an action plan to address any disparities observed.*

Amerigroup developed a specific Cultural and Linguistic Appropriate Services (CLAS)/Healthcare Disparities (HCD) Program Description, Work Plan (which includes any actions taken) and Annual Assessment focusing on healthcare disparities in 2016. The work plan outlines all data reviewed to determine potential disparities, as well as any actions taken to identify or address barriers. Amerigroup identified several operational barriers which were addressed in 2016, and will continue to monitor for potential healthcare disparities in 2017.

- *The plan should continue its efforts with regards to provider recruitment and improving access to care for dentists, adult primary care physicians (PCPs), children's PCPs, hospitals and specialists in the deficient counties.*

Amerigroup continues to use geo access reports to monitor network adequacy and to develop targeted recruitment plans in the event a network gap is identified, as is listed and addressed below:

PCPs and Specialists

Specialists/Warren - Our Q1 2017 geoaccess report demonstrates that Amerigroup meets all specialty requirements in Warren County, with the exception of endocrinology. Amerigroup is focused on identifying an additional endocrinologist for recruitment in this county that will agree to participate in the network. While Amerigroup continues to make best efforts to recruit this provider type, the single case agreement (SCA) process will be utilized should any members require such services. Additionally, Amerigroup will coordinate any required transportation for members.

Adult PCPs/Hunterdon - Hunterdon Medical Center has not been willing to contract despite numerous attempts made by Amerigroup to do so. As a result of the Hospital's position, the physicians affiliated with the hospital- affiliated IPA in the county also refuses to contract with Amerigroup. To that end, Amerigroup continues to ensure its members have access to any needed providers in Hunterdon county through the health plan's single case agreement (SCA) process. Amerigroup's hospital team will continue to periodically (bi-annually) outreach to the facility to seek opportunities to contract the facility into our network.

Dental

While Amerigroup was unable to cure the deficiencies in Atlantic, Gloucester and Morris counties Network Development has been working diligently to cure these county deficiencies. For Atlantic County recruitment efforts have been focused in the deficient towns of Egg Harbor, Egg Harbor City and Mays Landing. Network Development has successfully recruited and panel placed a provider in Mays Landing. For Gloucester County recruitment efforts have been focused in the deficient towns where the majority of the members reside. These include: Franklinville and Mullica Hill. Network Development has successfully recruited and panel placed two providers in Swedesboro. For Morris County recruitment efforts have been focused in the deficient towns of Kinnelon and Lake Hopatcong. While some providers have joined the network, others have left the network. Successful recruitment was accomplished by continuing to pursue non-participating and non-interested offices approximately every 6 months. Amerigroup had personalized discussions with the providers to address fees, claims, potential patient issues, and concerns about participating on a government plan. This system appears to have worked well. Utilizing this same approach, Amerigroup feels close to reaching an agreement with various providers which would result in curing these deficiencies. Amerigroup continues to use this

approach with the counties that are not deficient in order to continually improve the network. Amerigroup recruits dentists by attending trade shows in New Jersey, utilizing online provider listings (www.yellowpages.com/www.superpages.com, NJ Dental Association at www.njda.org), competitor provider directories and Healthplex internal databases. Grassroots efforts have even included door to door recruiting. Dental provider offices have been mailed recruitment packets with a competitive fee schedule and follow up calls are being made.

Hospitals

Hunterdon

Amerigroup has approached Hunterdon Medical Center, the only acute care facility in the county, since 2012 for the purpose of contracting but the hospital refuses to contract with another Medicaid MCO. Amerigroup will continue the outreach efforts. Members may continue to access the ER at Hunterdon Medical Center as necessary. Amerigroup will negotiate a Single Case Agreement (SCA) with this facility if elective services are needed/approved. Amerigroup currently has in network hospital(s) in the adjacent counties of Warren, Somerset, Mercer and Morris. If services are needed/approved in adjacent counties, Amerigroup will coordinate transportation through LogistiCare Medical Transportation.

Ocean

Amerigroup currently has Community Medical Center and Monmouth Medical Center-Southern Campus in network in Ocean County. In an effort to increase access within the county, Amerigroup is currently in discussions with Hackensack Meridian Health to evaluate the potential for contracting with the Plan. Members may continue to access the ERs at Hackensack Meridian Health as necessary. Amerigroup will negotiate a Single Case Agreement (SCA) with Hackensack Meridian Health if elective services are needed/approved. Amerigroup currently has in network hospital(s) in the adjacent counties of Monmouth, Burlington and Atlantic. If services are needed/approved in adjacent counties, Amerigroup will coordinate transportation through LogistiCare Medical Transportation.

Warren

Amerigroup currently has Hackettstown Regional Medical Center in Hackettstown, Warren County, NJ in network. In an effort to increase access within the county, Amerigroup has approached St. Luke's Warren hospital since late 2013 for the purpose of contracting but the hospital has failed to respond in a meaningful way. Amerigroup will continue the outreach efforts. Members may continue to access the ER at St. Luke's Warren as necessary. Amerigroup will negotiate a Single Case Agreement (SCA) with this facility if elective services are needed/approved. Amerigroup currently has in network hospital(s) in the adjacent counties of Sussex and Morris. If services are needed/approved in adjacent counties, Amerigroup will coordinate transportation through LogistiCare Medical Transportation.

Sussex

Amerigroup is contracted with the only acute care hospital in Sussex County. Amerigroup currently has in network hospital(s) in the adjacent counties of Passaic, Warren and Morris. If services are needed/approved in adjacent counties, Amerigroup will coordinate transportation through LogistiCare Medical Transportation.

- *The plan should address areas where clinical performance fell below the NCQA 50th percentile.*

Amerigroup continues to monitor and maintain a HEDIS work plan for measures that fall below the 50th percentile. Through ongoing monitoring, the Quality Management (QM) Department identified and addressed opportunities to improve its outcomes. In 2016, QM enhanced its outreach process to further analyze the impact of its interventions, and utilized monthly benchmark reporting to track HEDIS progress throughout the year. Provider and member interventions were also further aligned for consistency (i.e. - incentive programs, provider HEDIS reports and member outreach). Regular cross departmental meetings were held to ensure consistent messaging from Amerigroup. Amerigroup increased its overall HEDIS score by 4 points (HEDIS 2015 to HEDIS 2016) and based on preliminary HEDIS 2017 reporting continues to improve its overall HEDIS rates.

- *The plan should review the deficiencies in their QIP processes through training and identification of consistent and analytic resources for QIP activities.*

Amerigroup hired an additional Analyst in the 2nd Quarter 2017. Due to changes in resource allocation, each QIP has a dedicated Analyst and QM nurse. The Medical Director and QM Director will be consulted for all QIPs. To ensure consistent and meaningful QIP activities, Amerigroup will be implementing monthly cross departmental workgroup meetings in August 2017 to review QIP progress, interventions and data. Staff will also continue to attend State QIP training in 2017.

- *The plan should develop processes to track timeliness of expedited member and provider appeals, to investigate member and provider grievances, and to resolve member and provider grievances.*

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

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

Provider Grievances are tracked on a centralized tracking database by Regulatory. Provider Relations leads the plan Grievance Team in coordinating weekly meetings with Regulatory and the representatives from MLTSS, Ancillary, Compliance and the Corporate Account Manager to ensure resolution in accordance with the required timeframes mandated by the State regulatory agencies. In addition, the team has reoccurring weekly meetings with the Provider Relations Director to review grievances for appropriateness and any necessary approvals. A desk top process has been created to outline the step-by-step process of handling same from receipt to closure in accordance with the required timeframes. Weekly reports are generated and tracked to resolution.

Quarterly reporting of all provider grievance appeal requests and dispositions for the reporting period is submitted for the reporting period on Table 3C. Effective with the Q2 2017 Table 3C submission, Amerigroup will be including all open cases to date.

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

Amerigroup has an automated process for calling all newly enrolled members to conduct an initial health screen (IHS) during the month of their enrollment. In addition to automated phone calls trying to reach you letters are sent to newly enrolled members with contact information for members to call Amerigroup to complete an IHS. Further attempts to complete an IHS for members on the monthly report that do not have a valid phone number are conducted by the plan.

- *The plan should develop a process to ensure timely development of a care plan for all members in MLTSS CM.*

Amerigroup consistently reviews MLTSS CM processes to meet contractual requirement of development of member-centric care plan within the 30 days of member visit. A weekly CM Monitoring Report is a tool utilized by the CM managers for staff oversight, which includes status of care plan development. In addition, a designated Clinical Manager evaluates the CM Monitoring Report and works in collaboration with CM Managers to confirm visits are completed by the 25th day of enrollment. If a member does not have POC completed by the 25th day of enrollment, CM Manager is to provide root cause for incomplete visit and implement an action plan that includes daily updates until

completion. Designated Manager compiles monthly reports on the progress of Care Plan development, which is reviewed with Clinical Leads weekly.

HNJH

HNJH addressed IPRO's CY 5 QTR recommendations as follows:

- *The plan should develop a work plan that addresses the areas of concern identified by the analysis of healthcare disparities. Following implementation of the work plan, the plan should conduct a formal analysis of the impact of the initiatives.*

HNJH developed a work plan in 2016 that addresses Health Care Disparities which were identified through an analysis of member data, including demographic and HEDIS data. The work plan is reviewed and updated monthly. Additionally, an analysis of member compliance with health screenings was conducted to identify additional disparities.

A barrier analysis is also conducted for each disparity topic on the work plan. A multi-disciplinary team contributes to and/or reviews the analysis. The barrier analysis will be refreshed semi-annually to monitor changes and opportunities. As interventions are implemented, outcomes and feedback received, are analyzed for barriers.

A barrier analysis has been conducted for the following measures that were identified in the Healthcare Disparities data analysis: Lead Screening in Children (LSC) - November 2016, Breast Cancer Screening (BCS) - December 2016 and May 2017, Cervical Cancer Screening (CCS) - December 2016 and May 2017. The outcome of the May 2017 barrier analysis for BCS and CCS was focused on IVR responses from members in 2016. The outcome of the analysis is that a significant amount of members responded that they "Don't Need" the screening (45% of CCS barrier responses and 33% of BCS barrier responses).

Preliminary findings were used to launch a Breast Cancer Screening (BCS) IVR campaign in November 2016 which targeted Atlantic, Camden, Essex and Hudson counties. The call campaign resulted in statistically significant impact to member compliance. Members who received the call message were 4.05% more compliant than the same cohort who did not respond to the call campaign.

Formal analysis of the impact of the initiatives is completed on a quarterly basis.

- *The plan should address areas where clinical performance fell below the NCQA 50th percentile.*

All of the HEDIS measures that fell below the NCQA 50th percentile are included in the HEDIS State Work Plan. In our work plan, we have documented in detail how we plan to improve these measures. The HEDIS 2016 work plan was submitted on August 15, 2016 with updates provided on October 16, 2016 and January 31, 2017. The performance expectation of the Work Plan is to achieve or exceed the 50th percentile through the new interventions that will be implemented. Each measure will be monitored monthly in the HEDIS work group meetings and reported at the Quality Improvement Committee quarterly. Quarterly evaluation of the effectiveness of interventions will allow for the development of additional interventions to improve outcomes. The HEDIS 2017 State Work Plan will be submitted on August 15, 2017. Additionally, 11 of 33 measures included in the 2016 plan demonstrated improvement and were removed from the 2017 work plan as the performance was above the 50th Percentile.

- *The plan should continue to identify and train the appropriate staff for the development, monitoring and reporting of QIPs.*

HNJH has identified the appropriate resources that have a direct responsibility for the development, monitoring and reporting of HNJH QIPs. These resources include the QM Medical Director, Quality Management & Administration Manager, Quality Improvement Manager, Quality Improvement Auditor.

Additionally, HNJH has also developed and implemented training in data analysis for the staff noted above. The training includes Horizon Lean Six Sigma training modules relating to identification and tracking of study populations, presentation of data in a consistent manner over time, presentation of study indicator metrics, analysis of ongoing tracking metrics that are designed to evaluate interventions, biostatistics and overall analysis of study results. This training is conducted on an annual basis.

The identified resources will also attend the Annual Quality Improvement Project (QIP) Training for Medicaid, MLTSS and FIDE SNP, which will ensure that the team has a clear understanding of the expectations aligned with QIP development, monitoring and reporting.

HNJH has also implemented an additional process to ensure that training is conducted on an ongoing basis. This process includes monthly meeting discussions where all appropriate QIP resources review the milestones, QIP feedback received from DMAHS, current challenges and potential opportunities.

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

The health plan was requested to submit a Corrective Action Plan (CAP) for the updated Outreach for General Care Management & DDD CAP to DMAHS on 9/20/16. The CAP was submitted on 10/20/16. CAP Approval from DMAHS received on 12/14/16.

New Initiatives include the following:
- Welcome call center staff to follow initial outreach process/workflow* *(CM Workbook)
- IHS <5, with identification of disease by Welcome Call Center staff will: task to CM for DM survey completion
- Revision of DDD Non-clinical staff workflow
- Primary responsibility is initial outreach
- Touch every newly identified member within the first week of the month identified
- The plan will monitor the timeliness of CNA completions and sign-off for timely Care Plan development.
- Weekly review of the DDD production tracking ratio for CNA completion and outreach
- Staff coaching for any staff identified as not meeting expectation

On-going efforts:
- Under-utilization report
- High utilizer report
- Re-admissions report

- *The plan should ensure completion of a CNA and timely and complete care plan for the DDD population. A care plan should be developed regardless of whether a member declines care management or is unreachable to complete a CNA.*

The health plan was requested to submit a Corrective Action Plan (CAP) for the updated Outreach for General Care Management & DDD CAP to DMAHS on 9/20/16. The CAP was submitted on 10/20/16. CAP Approval from DMAHS received on 12/14/16.

New initiatives include the following:
- DDD implemented a new non-clinical outreach workflow
- Revision of DDD Non-clinical staff workflow
- Primary responsibility is initial outreach
- Touch every newly identified member within the first week of the month identified

- Reaches out to MCO Helpdesk at first outreach, along with Outreach Letter and task for follow-up within 10 days
- Hired new staff to meet the demands of increased membership
- Medical Management System enhancements
- Incorporated DDD questions into the core CNA
- Dynamic Letter Attachments – Allowing staff to mail individualized educational material at member's request
- Revision of Clinical Work Flow to address timely CNA completion and timely Care Plan creation
- CNA completion triggers Care Plan for Care Manager to individualize based off member's identified needs
- The plan will monitor the timeliness of CNA completions and sign-off for timely Care Plan development

- *The plan should review its MLTSS Care Management process to ensure initial plans of care are completed within 30 days of enrollment using member centric principles; there is alignment between the initial plans of care and NJ Choice Assessments as well as back-up plans, as appropriate.*

Horizon updated its workflows December 12, 2016 to assure that members are seen within 30 days to complete their Initial Plan of Care and Back-up plans timely. Back up plans are now completed on all members residing in a community residence excluding Community Alternative Residential Settings CARS). To validate that the Initial Plan of Care has been completed and signed, a systemic option was added for attaching the signed copy of the Initial Plan of Care enabling reporting to monitor compliance. Plans of care are either handed to the member at the visit, or mailed to the member post visit. This is documented in the Medical Management System under contact reason specific and tracked for compliance. The MLTSS dashboard remains in use, and identifies a status including, when cases are due, or may be overdue. If any of the required timelines are out of compliance, this shows as red on the MLTSS dashboard and remediation of the Care Manager is completed by the supervisor and documented. HNJH currently has a Corrective Action Plan (CAP) in place for this requirement but has shown an over 30% increase in compliance from the previous year from 55.0% to 85.7%.

UHCCP

UHCCP addressed IPRO's CY 5 QTR recommendations as follows:

- *The plan should monitor effectiveness of the targeted interventions implemented to address health care disparities and should continue to monitor data at that plan level on an ongoing basis.*

The Healthcare Disparities work plan is updated quarterly to document the status and the effectiveness of the interventions implemented to address the disparate rates of breast cancer screenings and diabetic eye exams in African American members that reside in Essex County.

The following are new interventions that were added to the 2017 workplan

- New Breast Cancer screening clinic day invitation to feature an older woman and address fear
- Member Rewards program ($25.00 Gift Card) for completion of breast cancer screening and dilated eye exam.
- Onsite outreach at selected Provider's office to schedule appointments.

The NJ Disparity Activities/Barriers/Improvement report is a working document to record activities (clinic days), new barriers identified at a clinic day and recommendations or improvements implemented to address the barrier. To better understand this report, the following modifications were made to align the issues identified with improvements and results.

- 1. Barriers identified at each event
- 2. Recommended improvements or intervention to address barrier identified
- 3. Date improvement was implemented

- *The plan should take action to expand their dental network in Burlington County and Morris County to address deficiencies in access to General Dentists.*

Two dental provider advocates were hired in 2016 for account management and recruitment efforts in the dental network. Since September 2016 to current, the plan has corrected the Primary Care Dental provider deficiency consistently month-over-month at over 90% for both Morris and Burlington counties.

- *The plan should take action to expand their access to Acute Care Hospitals in Cumberland and Sussex Counties.*

Sussex County: the health plan is currently contracted with the only hospital in Sussex county, Newton Medical Center. Due to the physical location of the hospital and the size of the county, a mileage deficiency results. This deficiency is out of our control, as there is no other hospital within the county to fill that gap.

Cumberland County: The health plan and Inspira have been in ongoing negotiations since 2012 regarding the renewal of a provider contract agreement, which terminated in 2013. Inspira's willingness to renew their contract with UHC was contingent upon an agreement based on significantly enhanced rates that were well beyond what we can pay as an entity with fiduciary responsibility to manage Medicaid costs. Given that the health plan is still unable to contract at the enhanced rates proposed by Inspira, UHCCP has not had significant further discussions in writing with the hospital.

- *The plan should expand its MLTSS provider network to meet the required minimum of two providers per county. The plan should contract with at least one additional provider for Vehicular Modifications, and the need for Community Transition Services should be evaluated by county.*

As of September 2016 provider network reporting, the plan meets the minimum requirement of having two contracted Vehicular Modification providers per county for all counties. Community Transition Services providers are evaluated by Network Management to ensure member access by county with the minimum requirement of two providers per county fulfilled for all counties.

- *The plan should address areas where clinical performance fell below the NCQA 50th percentile.*

United Healthcare Community Plan prepared and submitted a Workplan to address results for measures from HEDIS 2016 which fell below the 50th percentile. The Workplan below describes interventions implemented to improve each measure and results.

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2016)	Results
Child Immunization Combo 3 and 10	1 - EPSDT reminder letter to members 2 - Educational articles in member and Provider newsletters 3 - Provider mailing: list of non-compliant members 4 - Automated calls to members via Silverlink 5 - CPC visits: Provider education related to timing and coding of immunizations. 6 - Schedule well-visit clinics with network Providers to get members in for needed services. 7 - Continue Accountable Care Community Partnerships w/FQHCs- CAMcare, Complete Care 8 - *Live outreach calls to members via QM Dept.	1. EPSDT well-visit reminder letters completed. 2. Article published in the Winter member newsletter: 'Why does my baby need so many shots'; Member newsletter article completed 1Q; Article published in Fall newsletter: Understanding EPSDT Requirements. Provider newsletter to be published in 2017. 3. Quarterly mailing to all EPSDT providers completed. 4. Calls completed: 21,016 5. CPC visits completed 149 6. Total number of events: 2 7. Partnership agreement and CPC education is ongoing 8. Calls completed: 4195; Members contacted: 910; Appointments scheduled: 360 9. Cobranded letters mailed: 21,309; Calls completed: 13,118 10. Ongoing

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2016)	Results
	9 - Cobranded letters and automated messaging from PCPs participating in program 10 - *Collect NJIIS data monthly. 11 - Plan for improved in-house medical record collection process in 2016 to collect data not coded. 12 - *Pfizer postcard mailing - well/reminder	11. Implemented 1Q 2016 12. Mailings completed: 20,195
Weight Assessment and Counseling (WCC) - **Total BMI**	1 - Educational articles in member newsletter 2 - CPC visits to provider offices to review HEDIS quality scores, provide list of non-compliant members with gaps in care. Provide WCC BMI codes and measure definition. 3 - Provider BMI incentive - $10 will be paid, once per year, per member. Eligible members are ages 3 to 17. 4 - Coordinate health events (well-visit clinic days to include weight assessment and counseling) with Providers participating in QIP and high volume practices. 5 - Cobranded letters/automated messaging from PCPs participating in program 6 - Plan for improved in-house medical record collection process in 2016 to collect data not coded. 7 - *Member movie ticket incentive for members participating in the QIP.	1. Article published in Spring member newsletter article - Teen Time. 2. CPC visits completed: 149 3. BMI incentive implemented and ongoing. 4. Total number of events: 2 5. Cobranded letters mailed: 21,309; Calls completed: 13,118 6. Implemented 1Q 2016 7. Members rewarded: 70
Diabetes HbA1c Poor Control >9.0%)	1 – Coordinate provider clinic days 2 - *Automated member education and reminder calls - Silver Link 3 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes. 4 - Supply educational information to members (Healthy Tips Diabetes/Blood Pressure booklet) 5 - Educational article in member newsletter 6 - Continue Accountable Care Community Partnerships w/ CAMcare, Complete Care 7 - Offer Accountable Care Community Partnerships w/ Newark Beth Israel, and Ocean Health Initiatives 8 - Plan for improved in-house medical record collection process in 2016 to collect data not coded.	1. Total number of events: 3 2. Calls completed through 3rd Quarter: 14,930 3. CPC provider visits completed: 149 4. Keep track of your health distributed at 3 clinic events. 5. Articled featured in member Summer newsletter: 'Under Control' 6. Ongoing 7. Partnership implemented with Ocean Health Initiatives 8. Implemented 1Q 2016
BP Control (<140/90)	1 - Educational articles in member and Provider newsletters 2 - Continue Accountable Care Community Partnerships w/ CAMcare, Complete Care and Metropolitan 3 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes	1. Articled featured in Summer member newsletter: 'Under Control' 2. Partnerships ongoing. 3. CPC provider visits completed: 149

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2016)	Results
Follow-Up Care for Children Prescribed ADHD Medication-Initiation (ADD) - Initial Phase	1 - Continue Member Mailings to members identified as having filled a new prescription for ADHD 2 -Send fax blast and annual newsletter articles to provider network 3 - CPC visits to provider offices to review HEDIS quality scores, provide list of non-compliant members with gaps in care and provide measure definition and HEDIS codes. 4 - Educational articles in member newsletter 5 - Cobranded letters and automated messaging from PCPs participating in program 6 - Live education and reminder calls to members in need of an appt within 30 days	1. Mailings completed 2Q 2. Fax blast sent October 2015. Article was published in Spring Provider newsletter: Follow Ups for Children on ADHD Medication 3. CPC provider visits completed: 145 4. Article was published in the Winter Member newsletter: The right care for ADHD 5. Cobranded letters mailed: 27,259; Calls completed: 10,645 6. Calls completed: 939; Members Reached: 175; Appointments Scheduled: 1
Follow-Up Care for Children Prescribed ADHD Medication-Initiation (ADD) - Continuation and Maintenance Phase		
Breast Cancer Screening	1 - Educational article in member newsletter 2 - Live calls via QM Dept. to members targeted for HC Disparity, women ages 40-51, and MLTSS - ages 75 3 - Coordinate mammography screening events 4 - Automated Member Calls - Silverlink 5 - Continue Accountable Care Community Partnership with Camden Coalition (11 practice groups) and Metropolitan 6. - *Member incentive Program ($15 gift card) for completion of mammogram 7 - *Create new mammography clinic day invitation 8 - *Conduct member focus group	1. Article published in the Spring member newsletter, 'Crush Cancer' 2. Calls completed: 14,526; Members contacted: 2,449; Appointments scheduled: 545 3. Total number of events held: 39 4. Calls completed: 50,075 5. Partnerships ongoing. 6. Members rewarded: 171 7. Invitation completed. 8. Member focus group completed.
Prenatal Care (PPC)	1 - Educational article in member newsletter 2 - Continue to send out Member Mailing from HFS 3 - Automated Calls for education and appts.- Silver Link 4 - Member outreach via QM staff - (for QIP Hudson County only) 5 - *CPC program being expanded to include OB/Gyn practices 6 - Continue Accountable Care Community Partnerships w/ CAMcare Camden Coalition, Metropolitan 7 - Offer Accountable Care Community Partnerships w/ Newark Beth Israel and Ocean Health Initiatives 8 - Plan for improved in-house medical record collection process in 2016 to collect data not coded. 9 - *Obtain list monthly of women who become	1. Article featured in Summer member newsletter: 'Before Baby' 2. Ongoing 3. Calls completed: 34,426 4. Calls completed: 3,816; Members contacted: 770; Appointments scheduled: 7 5. Provider site visits completed: 39 6. Partnerships ongoing. 7. Partnership implemented with Ocean Health Initiatives 8. Implemented 1Q 2016 9. Calls completed: 2,924; Members contacted: 457; Appointments scheduled: 10.

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2016)	Results
	eligible for Medicaid due to pregnancy. Outreach team to call members to assist with scheduling first appointment within 42 days of enrollment.	
Postpartum Care (PPC)	1 - Educational article in member newsletter 2- HFS to continue to mail postpartum packets 3 - Automated Member Calls - Silverlink 4 - *CPC program being expanded to include OB/Gyn practices 5 - Vendor (Alegis) to provide in-home postpartum services in targeted areas. 6 - *Member incentive ($15.00 gift card) for completion of postpartum visit 7 - Continue Accountable Care Community Partnerships w/ CAMcare, Camden Coalition and Metropolitan 8 - Offer Accountable Care Community Partnerships w/ Newark Beth Israel and Ocean Health Initiatives 9 - Plan for improved in-house medical record collection process in 2016 to collect data not coded. 10 - *Live Member calls via QM Dept. 11 -* Change 5 high volume OBs to FFS with payment for PPC visit	1. Article featured in Summer member newsletter: 'Before Baby' 2. HFS mailings ongoing 3. Calls completed: 20,014 4. Provider visits completed: 39 5. Appointments kept: 131 6. Members rewarded: 164 7. Partnerships ongoing 8. Partnership implemented Ocean Health Initiatives 9. Implemented 1Q 2016 10. Calls completed: 8,689; Members reached: 1,627; Appointments Scheduled: 49 11. 11. Contract implemented.
Frequency of Prenatal Visits (FPC)	1 - Educational article in member newsletter 2 - Continue to send out Member Mailing from HFS 3 - Automated Member Calls - Silverlink 4 - *CPC program being expanded to include OB/Gyn practices 5 - Continue Accountable Care Community Partnerships w/ CAMcare, Camden Coalition and Metropolitan 6 - Offer Accountable Care Community Partnerships w/ Newark Beth Israel, and Ocean Health Initiatives 7 - Plan for improved in-house medical record collection process in 2016 to collect data not coded.	1. Article featured in Summer member newsletter: 'Before Baby' 2. HFS mailings ongoing 3. Calls completed: 39,391 4. Provider visits completed: 39 5. Partnerships ongoing 6. Partnership implemented: Ocean Health Initiatives 7. Completed 1Q 2016
Controlling High Blood Pressure (CBP)	1 - Educational articles in member and Provider newsletters 2 - Continue Community Events 3 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes. 4 - Supply educational information to members (Healthy Tips Diabetes/Blood Pressure booklet) at events 5 - Provider mailing to identify non-compliant members with hypertension (65+yrs)	1. Article published in the Winter member newsletter, You have the Power'; Article featured in Summer member newsletter: 'Bring it Down'. Article published in the Fall Provider newsletter: Controlling Blood Pressure 2. Provider events: 1 3. Provider visits completed: 149 4. Keep track of your health distributed at BCS and diabetes clinic days. 5. Provider mailing completed February and December 2016 6. Completed 1Q 2016.

HEDIS Measure	Detailed intervention (s) taken by to address deficiency (* New Interventions proposed and/or implemented in 2016)	Results
	6 - Plan for improved in-house medical record collection process in 2016.	
Medication Management for People with Asthma (MMA) – 75%	1 - Automated Member Calls - Silverlink 2 - Educational articles in member and Provider newsletters 3 - CPC visits to provider offices to review HEDIS quality scores, provide non-compliant members list and educate on measure definition and HEDIS codes. 4 - Continue Accountable Care Community Partnerships w/FQHCs- CAMcare, Complete Care 5 - Cobranded letters and automated messaging from PCPs participating in program 6 - *Live calls via QM Dept.	1. Completed Calls: 1,798 2. Article featured in Fall member newsletter: Breathe Deeply - Understanding your asthma medication 3. Provider visits completed: 149 4. Partnerships ongoing 5. Letters mailed: 21,309; Calls completed: 13,118 6. Calls completed: 1,682; Members reached: 249; Appointments scheduled: 4
Annual Monitoring for Patients on Persistent Medications (MPM) Digoxin	1 - Educational article in Provider newsletter	1. Article published in Fall Provider newsletter: Annual Monitoring for Patients on Persistent Medications

*New activity for 2016

- *The plan should identify and develop staff with regards to QIP development and implementation.*

The team has been enhanced to manage all QIPs and provide consistency to the process. Additional staff was added in 2017, to ensure that QIPs continue to be a major focus of the Quality division, including, enhanced analyses, surveillance and collaboration with all divisions that are responsible for interventions and data reports.
This team continues to include the Director of Quality, the Manager of Quality, the Clinical Quality Nurses and other Quality managers that assist with the QIPs. The team continues to be supported by the Medical Director and a quality analyst. Routine review of the QIP continues and at times, may require change in methodology as a result of the QIP's performance. A process was enhanced to track the results of the QIP prior to the change in methodology in order to compare results over time and draw appropriate conclusion.
Additional trainings were implemented for the staff involved in the process and/or interventions. Meetings with the leadership teams of other divisions involved in the QIPs are now in place to ensure that the QIPs continue to be a focus for all collaborating divisions.

- *The plan should ensure documentation of the level of care management needed for the DDD population.*

The care level is entered for all DDD members in the system (Care One and ICUE). All reports are pulled directly from the system and track the care level for each member. This is tracked and reported quarterly at the Healthcare Quality Utilization Management Subcommittee.

In addition, quality audits are performed on a monthly basis to monitor accuracy of the level of each case and documentation in support of the care plan. To date all DDD staff meets or exceed performance metrics.

- *The plan should review its MLTSS Care Management process to ensure initial plans of care are completed within 30 days of enrollment using member centric principles and back-up plans are completed, as appropriate.*

Within five (5) business days of the effective date of a new member's enrollment into the MLTSS program, the assigned Care Manager will initiate contact with the Member to establish a time for completion of the face-to-face visit for the purposes of creating an individualized member centered comprehensive plan of care. In addition, if the Member resides in a nursing facility or other community alternative residential setting, the Care Manager, will also contact the facility to inform the facility of the Member's enrollment and visit date. The initial contact may be made via telephone. The Care Manager will confirm the scheduled interview prior to the meeting and ensure that Member and the (Member Representative if applicable) will be able to attend. The Member must be present for, and be included in, the on-site visit. If the Member is unable to participate due to cognitive impairment, the Member is a minor child and/or the Member has a legal guardian, the Care Manager shall ensure that the Member's authorized representative participates in the assessment and care planning activities. The Care Manager will complete the face-to-face visit to initiate service planning within forty five (45) calendar days of the Member's effective date of MLTSS enrollment.

The MLTSS Care Manager and Member/Member Representative collaboratively develop a Plan of Care and Back-up Plan if applicable based on the member's needs within 45 days of Member's enrollment in MLTSS. The Plan of Care addresses Member's unmet needs, their member centered personal goals, risk factors, and back-up plans. MLTSS Care Managers stress prevention, continuity of care and coordination of care, advocating for, and linking Members to appropriate services, providers and settings. MLTSS Care Managers facilitate and coordinate access to services, both clinical and non-clinical, by connecting the Members to resources that support their participation in an active role in the self-direction of their care needs. Care Manager's review and update the Plan of Care and Back-up Plan at a minimum every quarter or more frequently if the members encounters a change in condition or placement.

MLTSS Care Managers develop the Back-up Plan in collaboration with the Member/Member Representative during the initial assessment. The back-up plan is reviewed and if appropriate revised if during the member's POC visits, with any change in condition more frequently as needed. The Back-up Plan is triggered when the Member, Caregiver, Provider or the Care Manager becomes aware of a gap in care or when a Caregiver identifies an unsafe or threatening environment at the Member's residence. The Back-up Plan includes information about actions that the Member should take to report any gaps in care to the Care Manager permitting the Care Manager to assist the Member in engaging the Back-up Plan. The Member has the right to revise the Back-up Plan and change preference level at any time. The Back-up Plan includes the care management telephone number empowering the member to contact the MLTSS care management team twenty-four (24) hours a day, seven (7) days per week. A copy of the Back-up Plan is provided to the Member /Member Representative upon development and during the Plan of Care visits, an additional copy is saved in the Member's electronic record. The Back-up Plan requires the Member/Member Representative signature. Care Managers document in the Member's record implementation of the Back-up Plan and actions taken including dates the Back-up Plan was reviewed /revised.

The Care Manager must continually evaluate the plan of care to update and/or revise it to accurately reflect the Member's needs and goals. The plan of care must be signed by the Member/ Member Representative with every review regardless if changes have been made. The Member/Member Representative document their agreement or disagreement with the POC. If the CM is unable to obtain the Member's /Member Representative's signature following the POC development, the CM will mail the POC to the Member/Member Representative for their signature and will mail the POC to the PCP. The Care Manager will assign them an activity to follow up 20 days after the POC has been mailed for receipt of the Member/Member Representative's signature. Effective 4/1/17 the Care Manger will also make a telephone call to the Member/Member Representative reminding them of the need for their signature.

The plan of care is developed upon:

- Face to Face NJ Choice assessment system
- Options Counseling and Interim Plan of Care
- Recommendations from the Member's primary care provider (PCP)
- Input from formal and informal providers, as applicable

Member goals should be:

- Be Member centered /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,

Documentation of the Member's agreement/disagreement with the following statements will be documented on the Member's plan of care and maintained in the Member's electronic Care Management record:

1. I agree with the plan of care,
2. I had the freedom to choose the services in the plan of care,
3. I had the freedom to choose the providers of my services based on available providers,
4. I helped develop this plan of care,
5. I am aware of my rights & responsibilities as a Member of this program.
6. I am aware that the services outlined in this plan of care are not guaranteed.
7. I have been advised of the potential risk factors outlined in this plan of care.
8. I understand and accept these potential risk factors.
9. I understand and accept that a backup plan will be initiated as stated in my plan of care

MLTSS Care Managers receive ongoing state specific training concerning Options Counseling, Interim Plan of Care (IPOC) and the Home and Community Based Services (HCBS) POC. The expectation is that they use member-centered problems, goals and interventions (PGI's) that speak to the needs of each individual Member. Options Counseling, in conjunction with the IPOC is also member -centered as the CM is discussing potential services with the Member/Member Representative and developing the IPOC. MLTSS Care Managers review, document and update the POC and Back-up Plan at every touch point to ensure there are no gaps in care and that the Member's needs are being met. The Care Managers have access to all MLTSS Policies and Procedures and receive ongoing training and education with any policy update.

WCHP

WCHP addressed IPRO's CY 5 QTR recommendations as follows:

- *The plan should take immediate action to improve its Medicaid compliance across all standards, especially in those areas that scored at or below 50% compliance, namely Quality Management, Efforts to Reduce Healthcare Disparities, and Committee Structure.*

1. Quality Management Committee Structure

a. The Plan continues to solicit providers of our special needs population for committee participation.
b. Dental Advisory Committee (DAC) meets quarterly.
c. Provider Advisory Committee (PAC) meets quarterly.
d. QI policy and procedure related to committee structure and maintenance of committee documents implemented and reviewed annually.
e. The Plan Dental Director attends the QIC meetings quarterly.

2. Efforts to Reduce Healthcare Disparities

a. Population Health Committee will continue to analyze member data (HEDIS cross referenced with WellCare's Population Assessment Report including SNJ State Health Assessment Data Report and Healthy NJ 2020 Health Disparities) to identify healthcare disparities.

- *The plan should develop and implement an analysis plan to evaluate healthcare disparities for its population. Following the formal evaluation of existing disparities, the plan should undertake a barrier analysis and develop an action plan to address the disparities observed.*

Health Disparities
1. Population Health Committee analyzed member data (HEDIS cross referenced with WellCare's Population Assessment Report including NJ State Health Assessment Data Report and Healthy NJ 2020 Health Disparities) to identify healthcare disparities.
2. Lead brought to Population Health Committee as a potential Health Disparity.
3. Analysis of disparity and barriers conducted; development of potential action plan
4. Lead Project Proposal and Analysis and asthma presented to the Population Health Committee as potential disparities; committee selected lead as Health Disparity.
5. Lead Project Proposal accepted by Population Health Committee included an action plan (interventions and timeline) and process for continuous monitoring.
6. Action plan implemented.
8. Health Disparities in Lead Blood Level Screening Proposal presented at Provider Advisory Committee (PAC).
9. Lead screening rates are monitored quarterly for race/ethnicity and county, and monthly for members residing in the city of Newark.
10. Data evaluated for 2016 with quantitative and qualitative analysis, and recommendations for 2017.

- *The plan should expand its adult PCP network in Mercer and Morris Counties, its pediatric PCP network in Mercer, Morris, and Somerset Counties, its dental network in Morris and Somerset Counties, and its hospital access in Sussex County.*

WellCare is 100% compliant for Adult PCP in the County. Our recruitment efforts are ongoing in efforts to build a strong Network. The Network Run of Adult PCP's that are currently credentialed, meets State requirement, and represents an adequate Network in Morris County. At the end of Q416, WellCare credentialed 179 Adult PCP's to meet the Network requirement.

As of 5/19 we are at 87.3% for the Pediatric PCP network in Morris County. Recruitment efforts are ongoing. WellCare is anticipating network adequacy for the Pediatric PCP network within the next 60 days. We have pediatricians in the process of being credentialed.
The Liberty Dental Plan's GeoAccess report was reviewed. Morris County was found to be deficient at 84.4%. WellCare's dental director has met with the vendor to identify barriers and opportunities to improve the network. Recruitment efforts are ongoing to cure the deficiency.

To meet the network requirement for Sussex County, WellCare has contracted with Newton Medical Center in Sussex County with an effective date of 3/31/2016.

- *The plan should develop a method to monitor their MLTSS HCBS provider network.*

WellCare's Network Integrity team will continue to provide reports from Geo Access to ensure that the data includes Zip Code Map points. We continue to monitor the network thru GEO ACCESS reports and directory pull. The current network for MLTSS providers are as follows:

HCBS- AMDC- over 100 locations- at least 2 per county except for Cape May, Gloucester, and Salem where we have 1 per county. (Continue recruitment efforts in Hunterdon, Ocean, Sussex, and Warren counties)
HCBS- PCA/home maker- over 200 locations at least 2 or more per county expect for Cape May, Gloucester, Salem, and Hunterdon, Warren where we have 1 per county and continue recruitment efforts.
HCBS- Nursing Home Custodial Care- over 200 facilities in network across the state
TBI- all 6 TBI providers care contracted with WellCare
Home delivered meals- 1 provider state wide (recruitment efforts continue)
PERS- 4 providers state wide
Home Modification providers- 3 state wide
Vehicle modification providers- 2 state wide
ALS/ALP- 69 providers in network

In response to deficiencies of Adult Family Care, there are 5 Adult Family Care in the state of NJ, 4 are listed in Essex County, 1 in Camden County. WellCare has contracts with CARE MANAGEMENT 2000, ROYAL HOMECARE MANAGEMENT cover Essex County and SENIOR CITIZENS UNITED COMMUNI covers Camden County. In regards to noted deficiencies for Assisted Living Group, there are 13 Assisted Living Groups facilities in the State, WellCare has contract with 5 and continues recruitment efforts. The plan continues to use a flat file for monitoring purposes. The flat file will be review quarterly.

- *The plan should develop a process to track timeliness of Member Appeals, Provider Appeals and Member Grievances to ensure all are handled within the required timeframes. The plan should also include monitoring of provider performance against quality performance metrics and utilization metrics, as well as enrollee satisfaction surveys during the recredentialing process.*

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

Delegation Oversight revised the tools used for annual audits of recredentialing of in accordance with NJ Medicaid Contract, with the addition that during recredentialing process review includes also data related to performance indicators and utilization as applicable. Audit tools were updated and finalized in late 2016 with the requirement for delegated entity to have a compliant Policy and Recredentialing Provider Files that demonstrate compliance. Delegation Oversight auditors received the updated tools and completed remainder of year 2016 NJ audits. Going forward, they will use the updated tools. Delegation Oversight adheres to WellCare's Credentialing Policies including C7CR-009-PR-001 that includes performance and UM data as part of Quality review for providers being recredentialed.
WellCare's Credentialing Department does document all re-credentialing files with notice that performance monitoring has been completed.

- *The plan should address areas where clinical performance fell below the NCQA 50th percentile.*

The Plan received NCQA accreditation in February 2017. The Plan has development and implements CAP's for HEDIS and CAHPS with monitoring timeframes.

- *The plan should identify and develop analytic staff to document QIP activities.*

1. The Plan hired a QI analyst 01/2017.
2. The Plan will continue to review and correct deficiencies per IPRO QIP evaluation.
3. Key QI and MLTSS staff to attend EQRO QIP Training.
4. The Plan will conduct quarterly analysis of data for each QIP.
5. The Plan will insure that key elements (interventions) can be operationalized before development and implementation of QIPs (existing and new).

- *The plan should ensure timely outreach (within 45 days of enrollment) and use of different outreach methods (minimum of 2 methods) to complete an IHS for newly enrolled General Population members. In addition, WCHP should ensure that methods used for early identification of members with potential care management needs target members with multiple emergency department visits and/or hospitalizations and members with newly diagnosed chronic conditions.*

Paper NJIHS Mailing Process and Data Mining through the Lead Assignment Warehouse (LAW)
1. In addition to telephonic outreach for IHS completion via Interactive Voice Recognition, WellCare mails a NJIHS to all members that have not successfully completed the NJIHS via telephonic attempts since Q4 2016. The paper NJIHS is sent via the Welcome Packet.
2. Eliza sends a weekly report to WellCare identifying members that are unable to contact. Those members receive a NJIHS mailed to the home address on file with a return envelope enclosed.
3. Once the NJIHS is received, the document is scanned into EMMA and uploaded into the screening to identify the final score. Anyone that triggers for CM (score 5 or more) is placed in the CM EMMA queue for outreach.
4. The Lead Assignment Warehouse is utilized to identify members with 3 or more ER visits and hospitalizations for CM intervention. Members are identified through predictive analytics of multiple data sources and classified into risk categories which define the level of intervention received. Members are scored based upon readmission risk, utilization, medical and behavioral risk, disease progression predictions and claims based algorithm that calculates a value of future adherence score (VFA).

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

1. Hospital based CM staff at St. Joseph's Hospital in Q2 2017 to engage members admitted and in the ER for CM intervention and assist with discharge planning. Upon discharge, members are linked to a care manager for additional outreach and interventions based on need.
2. Open cases weekly report created to monitor timeliness of assessment (NJ CNA) and care plan creation to maintain timeliness of completion. Created in Q4 2015
3. Outreach Step Action created Q3 2015 and staff refresher training completed in Q3 2016. Step Action outlines the outreach process including the amount of outreach attempts expected and timeliness of the process. Outreach Step Action is sent as a reminder to staff on a routine basis.
4. Some members are identified as unable to contact. They are referred to Field Outreach Coordinators, who assist in finding those difficult to reach members. The Field Outreach Coordinator is someone in the community that is familiar with community resources, such as homeless shelters and soup kitchens. If members are found, they are immediately connected care manager for outreach.
5. Continuous monitoring of staffing implemented monthly to identify the need for additional staffing resources and reduce caseloads of the General Population and DDD Teams. Implemented Q4 2015
6. Weekly monitoring of the case closure report for all cases closed as unable to contact and lost contact began in Q4 2016. All cases that were closed and found not to be following the Outreach Step Action are reopened for additional outreach.

- *The plan should ensure a timely and complete care plan for the DDD population. A care plan should be developed regardless whether a member declines care management services or is unreachable to complete a CNA.*

1. Open Cases Report implemented in Q4 2015 with continuous enhancement to monitor care plan creation and continuity of care review.
2. Caseloads decreased Q3 2016, upon hire of additional CMs to reduce caseloads and address compliance.
3. Care Monitoring Step Action refresher training to Care Managers completed Q3 and Q4 2016. All DDD members are in Care Management, where their cases must remain open. Members are placed in Care Monitoring. Activities include, but are not limited to, quality outreach to include claims, service authorization reviews, primary care physician contact, and member/guardian contact. Care plans are to be updated per the assigned acuity level outreach designation.

4. Care Plan updates are monitored weekly by management to ensure compliance. CMs that are not compliant with outreach receive refresher training and continued occurrences results in a corrective action plan.
5. Multiple outreach attempts to Group Homes have been made Q4 2016 in addition to Q1 & Q2 2017 for collaboration initiatives and to complete the care plan.
6. Collaboration with the DDD offices via the DDD MCO Help Desk e-mail is utilized to contact the case worker and address member concerns as they arise.

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

1. Vaccine and Immunization records were added to the monthly quality audit tool for CCM and SCM cases in July 2015. Managers provide monthly feedback to care managers that are not addressing the topics within the care plan and case notes.
2. Refresher training completed for preventative services for all Care Managers Q1 2016.
3. The NJIIS System is utilized to obtain vaccine records on all pediatric cases.
4. Health Passport is obtained on all DCPP cases as outlined in the DCPP Step Action.
5. HEDIS Care Gaps are reviewed and addressed within the care plan.
6. Care Managers expanded the care plan to include immunization information and dental information (identifying the last visit date as well as the physician contact information). The service gap is monitored in the open cases report weekly. Care Managers educate the members on the needs and benefits of preventive health services and education. Education and outreach attempts are documented in the care plan.
7. Results of lead testing are documented in WellCare's database. For all members with a BLL of 8 or greater, a care management case is open and tracked.
8. Member education, in addition to attempts for outreach and intervention, are addressed per the acuity level outreach process (Ex. Acuity level 1 = minimum outreach every 4 weeks)

- *The plan should review its MLTSS Care Management process to ensure initial plans of care are completed within 30 days of enrollment using member centric principles and back-up plans are initiated as appropriate.*

Plan of Care:
1. Tracking of care plan completion reviewed and monitored via the following methods:
 - 1:1 case conference between Manager and CM are conducted based on identified need (e.g weekly, monthly)
 - Weekly scorecards
 - Monthly CM audits
2. Plans of Care reviewed and discussed in 1:1 case conferences between Manager and Care Manager to ensure that the member's plan of care was developed using "person-centered principles".
3. The weekly scorecard has the MCO's new members listed each month, CM assigned, date of MLTSS enrollment, date of initial face-to-face visit, and date of completed plan of care. Managers complete scorecards weekly for each CM to indicate timeliness for the initial face-to-face visit. The manager submits the scorecard to the director monthly for tracking of timeliness by team. The director reports findings to the VP of Health Services. Management uses findings to address individual care manager and team performance driving towards 90% timeliness compliance at minimum respectively.
4. New Care Managers (employed for less than 3 months) are required to submit name/ID of member for 100% of care plans for review by Manager/Supervisor at time of completion (prior to sending to member and/or rep) to ensure the plan of care is timely, complete, and patient centered. Once Manager/Supervisor review Care Plan and satisfied with contents/timeliness, Care Manager is notified that Care Plan can be sent to member/PCP. This is done within the required timeframe of 30 calendar days of MLTSS enrollment.
5. Development of improvement plans for Care Managers identified as not having met expected standards for timely completion, person centered principle etc.

6. Bi-weekly report incorporating Care Plan completion date are sent directly to all Managers for review
7. Full staff retraining done on developing plans of care using "person-centered principles" in July 2016.
8. The scope of WellCare's regular care management audits includes reviews of whether the POCs included in selected review cases were developed using the "person-centered principles"
9. Senior Care Manager position added to each team in April 2017 and two Supervisor positions added May 2017 to provide Managers with support in random reviews of records including Care Plan development using "person-centered principles" to ensure compliance with same.

Back-up Plan
1. Use of state approved back-up plan form since July 2016 upon notification by IPRO during audit visit.
2. Presence is tracked via CM audit.

CHAPTER 5 – CONCLUSIONS AND RECOMMENDATIONS

This report has provided an overview of activities and findings for April 2016–December 2017. The following section provides a summary of MCO-specific strengths and opportunities for improvement.

ABHNJ

ABHNJ had an enrollment of 40,264 for Core Medicaid and MLTSS as of December 2017, which represented 2% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2017 Annual Assessment of Operations Review.

In the Core Medicaid CM Audit, ABHNJ scored above 90% for Continuity of Care and Coordination of Services for the General, DDD, and DCP&P populations in 2016. The plan scored 100% for Identification and Coordination of Services for the DDD population, and 100% for Identification, Outreach, Continuity of Care, and Coordination of Services for the DCP&P population in 2016.

In the 2016 MLTSS HCBS CM Audit, ABHNJ scored above 90% for MLTSS Performance Measure #10 (Plans of Care aligned with members needs based on the results of the New Jersey Choice Assessment.)

In the 2016 MLTSS NF CM Audit, ABHNJ scored a total rate above 90% for including supplemental plans of care on file, member present and included in onsite visits and coordination of care.

Opportunities for Improvement

ABHNJ scored below 50% compliance in 1 of the 14 standards in the 2017 Annual Assessment of Operations Review. ABHNJ received a compliance score of 40% for Efforts to Reduce Healthcare Disparities. ABHNJ scored 70% for Programs for the Elderly and Disabled and 82% for Utilization Management, which were below the 85% standard.

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

Opportunities for improvement were identified in monitoring dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.

Opportunities of improvement were identified for timely member notification when a network provider terminates from the plan to ensure continuity of care.

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

Review of the plan's QIPs for the Reduction in Falls Among Home and Community Based Members in MLTSS showed deficiencies related to the implementation of QIP interventions and oversight of data collection to ensure the QIP intervention is contributing to a reduction of falls.

Review of the new EI QIP proposal in September 2017 on the topic, "Improving Developmental Screening and Referral Rates to Early Intervention for Children Aged 0-3 Years," showed deficiencies related to the study question (aim statement), study variables (performance indicators), identification of the study population and sampling methods, and data collection procedures.

In the Core Medicaid CM Audit, ABHNJ scored second to lowest for the General Population (67%), which was below the 80% standard. ABHNJ scored lowest for Identification (74%) for the General Population, which was also below the 80% standard.

During the 2016 MLTSS HCBS CM audit, the plan acknowledged system limitations resulting in lack of documentation in CM MLTSS files for review.

Based on the 2016 and 2017 MLTSS HCBS CM audits, ABHNJ has an opportunity to improvement in the following MLTSS Performance Measures: PM#8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), PM#9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), PM#9a (Member's plan of care is amended based on change of member condition), PM#11 (Plans of care developed using "person-centered principles"), PM#12 (MLTSS HCBS plans of care that contain a back-up plan) and PM#16 (Member training on identifying/reporting critical incidents). In 2017, an additional opportunity for improvement was identified for PM#10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment).

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AGNJ

AGNJ had an enrollment of 192,745 for Core Medicaid and MLTSS as of December 2017, which represented 12% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

AGNJ's compliance score for Efforts to Reduce Healthcare Disparities has improved from 50% in 2016 to 100% in 2017. AGNJ has successfully implemented and monitored results relating to Culturally and Linguistically Appropriate Services (CLAS), and has demonstrated improvement in availability of materials to members that reflect improved adherence to CLAS standards. The plan has also established baseline data for associates and providers with regard to CLAS standards.

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2017 Annual Assessment of Operations Review.

For HEDIS PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life; Comprehensive Diabetes Care (rates for HbA1c Poor Control [> 9.0%], HbA1c Control [< 8.0%], HbA1c Control [< 7.0%] for a Selected Population, and Medical Attention for Nephropathy); Frequency of Ongoing Prenatal Care – 81+ Percent of Expected Prenatal Visits; Chlamydia Screening (21–24 Years); Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (all submeasures); Adult BMI

Assessment; Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs); and Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years and 7–11 Years). For NJ State-specific PMs in MY 2016, the plan exceeded the 75th percentile for the CAP measure for the Total Medicaid population (25 Months–6 Years and 7–11 Years) and for the Other Low Income subpopulation (12–24 Months, 7–11 Years, and Total).

The plan's final June 2017 QIP submissions for Identification and Management of Adolescents Overweight and Obesity met overall compliance with the reviewed elements.

Core Medicaid CM audit scores for Identification, Outreach, and Preventive Services for the DDD population remained at 100%, and the scores for Continuity of Care and Coordination of Services improved to 100% in 2016. Identification score remained at 100% for the DCP&P population. Similarly, Coordination of Services for the General Population also remained at 100%. All five rates for the DDD and DCP&P populations were above 90%.

In the 2016 MLTSS HCBS CM audit, AGNJ scored 100% for MLTSS Performance Measure #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), 99% for PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment) and #16 (Member training on identifying/reporting critical incidents), and above 90% for PM #9a (Member's plan of care is amended based on change of member condition).

In the 2017 MLTSS HCBS CM audit, AGNJ scored above 90% for MLTSS PM #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment).

In the 2016 the MLTSS NF CM audit, AGNJ scored a total rate above 90% for including supplemental plans of care on file, member present and included in onsite visits and coordination of care.

Opportunities for Improvement

Access issues were identified for adult PCPs, pediatric PCPs, specialists, hospitals and dentists in several counties in the 2017 Annual Assessment of Operations Review.

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

Opportunities for improvement were identified in monitoring dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.

Opportunities of improvement were identified for timely member notification when a network provider terminates from the plan to ensure continuity of care.

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

Review of the Reduction of Preterm Births – Increasing Progesterone Utilization Rates QIP identified opportunities to implement interventions on a timely basis in order to have an effective impact on the overall outcome of the QIP. In 2017, the plan submitted a re-working of this QIP (Reduction of Preterm Births by 5%) that identified deficiencies related to QIP development in areas of goal setting, defining the study population, data collection procedures and improvement strategies.

Review of the Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population QIP identified opportunities to implement interventions on a timely basis in order to have an effective impact on the overall outcome of the QIP.

Review of the new EI QIP proposal in September 2017 on the topic, "Improving Developmental Screening and Referral Rates to Early Intervention for Children Aged 0-3 Years," showed deficiencies related to the project topic and relevance, study variables (performance indicators), and data collection procedures.

In the Core Medicaid CM Audit, AGNJ scored below the 80% standard at 79% for Preventive Services for the General Population.

During the 2016 MLTSS HCBS CM audit, AGNJ had issues related to the consistency of report dates, electronic signature dates and supporting information within each file.

Based on the 2016 MLTSS HCBS CM audit, AGNJ has an opportunity for improvement in the following MLTSS Performance Measures: #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #11 (Plans of care developed using "person-centered principles"), #12 (Plans of care contain a back-up plan). Additional opportunities for improvement were identified in the 2017 MLTSS HCBS audit in the following MLTSS PMs: #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), #9A (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles"), and #12 (Plans of care contain a back-up plan).

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

HNJH

HNJH had an enrollment of 871,766 for Core Medicaid and MLTSS as of December 2017, which represented 53% of the total New Jersey Medicaid and MLTSS enrollment.

Strengths

HNJH had no Access deficiencies in the 2017 Annual Assessment of Operations Review.

For HEDIS PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: Comprehensive Diabetes Care (HbA1c Control [< 7.0%] for a Selected Population), Immunizations for Adolescents (Meningococcal), Children and Adolescents' Access to Primary Care Practitioners (all submeasures), and Annual Dental Visits (all submeasures). For NJ State-specific PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: AAP, for the Dual Eligibles subpopulation (65+ Years) and the Disabled subpopulation (20–44 Years, 45–64 Years, and Total); and CAP, for the Total Medicaid population (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years), the Disabled subpopulation (12–24 Months, 25 Months–6 Years, 12–19 years, and Total), and the Other Low Income subpopulation (12–24 Months, 7–11 Years, 12–19 Years, and Total).

In the Core Medicaid CM Audit, rates for all five areas for the DDD and DCP&P populations either improved from 2015 to 2016, or remained the same at 100%. All rates, except for Outreach in the General Population, were above the 80% standard in 2016. Coordination of Services remained at 100% for the General Population.

The plan's September 2017 MLTSS QIP submission regarding the Prevention of Recurrent Falls among Managed Long Term Services and Supports (MLTSS) Members met overall compliance with the reviewed elements.

The plan's September 2017 Core Medicaid QIP submission regarding Improving Early Identification of Pregnancy and Birth Outcomes met overall compliance with the reviewed elements.

In the 2016 and 2017 MLTSS HCBS CM Audit, HNJH scored above 90% for MLTSS Performance Measure #10 (Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment), #12 (Plans of Care that contain a Back-up Plan), and #16 (Member training on identifying/reporting critical incidents).

In the 2016 MLTSS NF CM Audit, HNJH scored a total rate of 90% or above for including supplemental plans of care on file, member present and included in onsite visits and coordination of care.

Opportunities for Improvement

HNJH has not demonstrated quantitative monitoring of implementation of actions in the work plan for the Efforts to Reduce Healthcare Disparities standard.

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

Opportunities for improvement were identified in monitoring dental prior authorizations to ensure implementation and completion of dental treatment plans for members enrolled in the MCO.

Opportunities of improvement were identified for timely member notification when a network provider terminates from the plan to ensure continuity of care.

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

For MY 2016 HEDIS PMs, the Follow-up Hospitalization for Mental Illness measure had rates below the NCQA 25th percentile, and present significant opportunities for improvement.

Review of the new QIP proposal in September 2017 on the topic, "Improving Developmental Screening and Referral Rates to Early Intervention for Children Aged 0-3 Years," showed deficiencies related to data collection procedures.

The plan's CM compliance for Outreach remains an opportunity for improvement for the General Population (70%).

During the 2016 MLTSS HCBS CM Audit, HNJH experienced an issue related to the Cost Effectiveness evaluation form. The MCO acknowledged a system limitation enabling the auditor to view only the most current evaluation form present in the member's MLTSS care management file. Historical forms were not available for review.

Based on the 2016 and 2017 MLTSS HCBS CM Audits, HNJH has an opportunity for improvement in the following MLTSS Performance Measures: #9a (Member's Plan of Care is amended based on change of member condition), and #11 (Plans of Care developed using "person-centered principles).

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

UHCCP

UHCCP reported an enrollment of 481,836 for Core Medicaid and MLTSS as of December 2017, which accounts for 29% of the State's Medicaid and MLTSS managed care enrollment.

Strengths

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2017 Annual Assessment of Operations Review.

The plan demonstrated ongoing evaluation of the effectiveness of the healthcare disparities action plan and continues to move forward in addressing those areas where disparities are identified.

For HEDIS PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: Lead Screening in Children, Adolescent Well-Care Visits, Comprehensive Diabetes Care (HbA1c Poor Control [> 9.0%], HbA1c Control [< 8.0%], and HbA1c Control [< 7.0%] for a Selected Population), Immunizations for Adolescents (Meningococcal, Tdap/Td, and Combination 1), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Counseling for Physical Activity – 12–17 Years), Follow-up After Hospitalization for Mental Illness (7-Day Follow-up), Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs and Total), Children and Adolescents' Access to Primary Care Practitioners (all submeasures), and Annual Dental Visit (all submeasures, except 2–3 Years). For NJ State-specific PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: AAP, for the Total Medicaid population (65+ Years), the Dual Eligibles subpopulation (20–44 Years, 45–64 Years, 65+ Years, and Total), the Disabled subpopulation (45–64 Years), and the Other Low Income subpopulation (65+ Years); and CAP, for the Total Medicaid population (12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years), the Disabled subpopulation (12–24 Months, 25 Months–6 Years, 12–19 years, and Total), and the Other Low Income subpopulation (12–24 Months, 7–11 Years, 12–19 Years, and Total).

The plan's September 2017 MLTSS QIP submission regarding Members with History of Falls met overall compliance with the reviewed elements.

In the Core Medicaid CM Audit, the plan performed well across all CM categories for the General, DDD, and DCP&P populations; all of the 15 CM compliance scores remained above the 80% standard from 2015 to 2016. All of the rates for the DDD and DCP&P populations were at or above 90% in 2016, and three of the five rates were above 90% for the General Population.

In the 2016 MLTSS HCBS CM Audit, UHCCP scored above 90% for MLTSS Performance Measure #9 (Member's plan of care is reviewed annual within 30 days of the member's anniversary and as necessary), #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment), and #12 (Plans of care that contain a back-up plan).

In the 2017 MLTSS HCBS CM Audit, UHCCP scored 90% for MLTSS Performance Measure #10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment).

In the 2016 MLTSS NF CM Audit, UHCCP scored a total rate above 90% for having the member present and included in onsite visits.

Opportunities for Improvement

The plan had deficiencies in access to dentists and hospitals. The plan also had deficiencies in appointment availability for new or transferred patients in the third trimester for obstetric care. The plan also did not demonstrate the adequacy of its MLTSS provider network.

The plan did not demonstrate that it is able to identify populations and run reports accurate reports for the annual Core Medicaid/MLTSS audit. The plan also did not provide accurate file universes for onsite file review.

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

Opportunities of improvement were identified for timely member notification when a network provider terminates from the plan to ensure continuity of care.

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

Review of the new QIP proposal in September 2017 on the topic, "Improving Developmental Screening and Referral Rates to Early Intervention for Children Aged 0-3 Years," showed deficiencies related to the study question (aim statement) and improvement strategies (interventions).

Based on the 2016 MLTSS HCBS CM audit, UHCCP has an opportunity for improvement in the following MLTSS Performance Measures: #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9a (Member's plan of care is amended based on change of member condition), and #11 (Plans of care developed using "person-centered principles"). While the plan scored above 85% for PM#8 in the 2017 audit, additional opportunities were identified in the 2017 MLTSS HCBS CM audit to include the following MLTSS PMs: #9 (Member's plan of care is reviewed annual within 30 days of the members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles"), and #12 (Plans of care that contain a back-up plan), and #16 (Member training on identifying/reporting critical incidents).

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

WCHP

WCHP reported an enrollment of 64,193 for Core Medicaid and MLTSS as of December 2017. This was 4% of New Jersey's Medicaid and MLTSS managed care enrollment.

Strengths

The plan's compliance score for the Core Medicaid/MLTSS annual review has continually improved in the past four years (56% in 2014, 72% in 2015, 87% in 2016, and 98% in 2017).

The plan has implemented and evaluated a comprehensive QAPI program that met all of the compliance standards in the 2017 Annual Assessment of Operations Review.

In the 2017 Annual Assessment of MCO Operations audit, the plan's Population Health Committee minutes demonstrated excellent use of plan and national data to inform the work of the committee as it relates to healthcare disparity. Each successive meeting showed the evolution of the committee members' understanding of the issues in healthcare disparities and an awareness of the issues most pertinent to their population. Through this work, the plan decided a topic of relevance to their membership and implemented a well-formulated work plan to address the issue.

For HEDIS PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: Adolescent Well-Care Visits, Immunizations for Adolescents (Tdap/Td), Annual Monitoring for Patients on Persistent Medications (ACE Inhibitors or ARBs, Diuretics, and Total), Children and Adolescents' Access to Primary Care Practitioners (25 Months–6 Years, 7–11 Years, and 12–19 Years), and Annual Dental Visit (2–3 Years). For NJ State-specific PMs in MY 2016, the plan exceeded the 75th percentile for the following measures: AAP, for the Dual Eligibles subpopulation (65+ Years and Total), for the Disabled subpopulation (45–64 Years), and for the Other Low Income subpopulation (65+ Years); and CAP, for the Total Medicaid population (25 Months–6 Years, 7–11 Years, and 12–19 Years) and the Other Low Income subpopulation (12–24 Months, 7–11 Years, and Total).

The plan's September 2017 Core Medicaid QIP submissions for Improving the Identification and Management of Pediatric Obesity in 12-17 Year Old Medicaid Population met overall compliance with the reviewed elements.

In the Core Medicaid CM Audit, the plan scored 100% for all areas for the DDD population. All rates across the General, DDD, and DCP&P populations either remained the same or increased from 2015 to 2016 (with the exception of the Coordination of Services rate for the DCP&P population that decreased 1 percentage point to 98%).

In the 2016 MLTSS HCBS CM Audit, WCHP scored 100% for MLTSS Performance Measure #9 (Member's plan of care is reviewed annually within 30 days of the member's anniversary and as necessary), and above 95% for PM#10 (Plans of care are aligned with members needs based on the results of the NJ Choice Assessment).

In the 2016 MLTSS NF CM Audit, WCHP scored a total rate above 90% for including supplemental plans of care on file, and coordination of care.

Opportunities for Improvement

Access issues for pediatric PCPs, dental providers, and hospitals were noted in some counties; and monitoring of the MLTSS HCBS network was lacking.

The plan made significant progress in addressing healthcare disparities. The plan formed a committee which used WCHP and national data to identify relevant topics related to disparities in care for the plan's membership, developed a work plan, and implemented interventions that were monitored quarterly. However, the impact of the interventions for year one of the initiative could not yet be evaluated at the time of the review.

The files presented for the 2017 Core Medicaid/MLTSS Annual Assessment file review exhibited untimely resolution of member appeals (MLTSS), provider complaints (Core Medicaid) and provider grievances (MLTSS). (Note that complaints

will not be included in the Annual Assessment of MCO Operations in the future, as this is not a contractual requirement for the 2018 annual assessments.)

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

Review of the plan's submission for the Reducing the Rate of Preterm Births in the NJ Medicaid Population QIP identified opportunities for improvement related to the development and implementation of interventions.

Review of the plan's submission for the Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall QIP identified opportunities for improvement related to the development and implementation of interventions.

Review of the new QIP proposal in September 2017 on the topic, "Improving Developmental Screening and Referral Rates to Early Intervention for Children Aged 0-3 Years," showed deficiencies related to data collection procedures.

Identification (80%) and Preventive Services (65%) for the General Population remain to be opportunities for improvement in Core Medicaid CM.

Based on the 2016 MLTSS HCBS CM Audit, WCHP has an opportunity for improvement in the following MLTSS Performance Measures: #8 (Initial plan of care established within 30 days of enrollment into MLTSS/HCBS), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles"), #12 (Plans of care that contain a back-up plan), and #16 (Member training on identifying/reporting critical incidents). While the plan demonstrated improvement in PM#8 in the 2017 audit, additional opportunities were identified in the 2017 MLTSS HCBS CM Audit to include the following MLTSS PMs: #9 (Member's plan of care is reviewed annual within 30 days of the members anniversary and as necessary), #9a (Member's plan of care is amended based on change of member condition), #11 (Plans of care developed using "person-centered principles), and #12 (Plans of care that contain a back-up plan), #16 (Member training on identifying/reporting critical incidents).

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX: April 2016–December 2017 MCO-Specific Review Findings

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ABHNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

ABHNJ 2016 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	8	3	8	6	2	0	75%	2	2	0
Quality Assessment and Performance Improvement	10	3	10	9	1	0	90%	1	4	0
Quality Management	13	4	13	7	6	0	54%	5	2	1
Efforts to Reduce Healthcare Disparities	4	0	4	2	2	0	50%	2	1	0
Committee Structure	9	1	9	5	4	0	56%	4	3	0
Programs for the Elderly and Disabled	44	20	44	27	17	0	61%	12	11	5
Provider Training and Performance	11	6	11	7	4	0	64%	3	1	1
Satisfaction	4	0	4	2	0	2	100%	0	0	0
Enrollee Rights and Responsibilities	8	6	8	8	0	0	100%	0	1	0
Care Management and Continuity of Care	37	25	37	31	6	0	84%	2	5	4
Credentialing and Recredentialing	10	3	10	8	1	1	89%	1	4	0
Utilization Management	22	19	22	13	9	0	59%	2	0	7
Administration and Operations	13	10	13	12	1	0	92%	0	2	1
Management Information Systems	18	16	18	16	1	1	94%	0	0	1
TOTAL	**211**	**116**	**211**	**153**	**54**	**4**	**74%**	**34**	**36**	**20**

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

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

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

ABHNJ 2017 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	8	6	8	7	1	0	88%	1	1	0
Quality Assessment and Performance Improvement	10	9	10	10	0	0	100%	0	1	0
Quality Management	17	7	17	15	2	0	88%	2	4	0
Efforts to Reduce Healthcare Disparities	5	2	5	2	3	0	40%	2	0	1
Committee Structure	9	5	9	9	0	0	100%	0	4	0
Programs for the Elderly and Disabled	44	27	44	30	13	1	70%	8	8	5
Provider Training and Performance	11	7	11	10	1	0	91%	1	3	0
Satisfaction	4	2	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	31	37	35	2	0	95%	2	4	0
Credentialing and Recredentialing	10	8	10	9	1	0	90%	0	1	1
Utilization Management	22	13	22	18	4	0	82%	4	5	0
Administration and Operations	13	12	13	12	1	0	92%	0	1	1
Management Information Systems	18	16	18	17	0	1	100%	0	1	0
TOTAL	**216**	**153**	**216**	**186**	**28**	**2**	**87%**	**20**	**33**	**8**

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

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

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

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

ABHNJ Performance Measures

ABHNJ HEDIS 2016 Performance Measures

ABHNJ HEDIS 2016 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	NA	R
Combination 3	NA	R
Lead Screening in Children (LSC)	NA	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	NA	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	58.33%	R
Adolescent Well-Care Visits (AWC)	38.27%	R
Breast Cancer Screening (BCS)	NA	R
Cervical Cancer Screening (CCS)	29.61%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	NA	R
HbA1c Poor Control (>9.0%)[1]	NA	R
HbA1c Control (<8.0%)	NA	R
HbA1c Control (<7.0%) for a Selected Population	NA	R
Eye Exam	NA	R
Medical Attention for Nephropathy	NA	R
Blood Pressure Controlled <140/90 mm Hg	NA	R
Controlling High Blood Pressure (CBP)	44.44%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	80.47%	R
Postpartum Care	53.91%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	57.81%	R
Immunizations For Adolescents (IMA)		
Meningococcal	NA	R
Tdap/Td	NA	R
Combination 1	NA	R
Appropriate testing for children with pharyngitis (CWP)	NA	R
Chlamydia Screening (CHL)		
16-20	NA	R
21-24	NA	R

ABHNJ HEDIS 2016 Performance Measure	Rate	Status
Total	NA	R
BMI assessment for children/adolescents (WCC)		
3-11	66.67%	R
12-17	NA	R
Total	65.33%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	NA	R
Continuation and Maintenance Phase	NA	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Adult BMI Assessment (ABA)	NA	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	NA	R
Digoxin	NA	R
Diuretics	NA	R
Total	87.23%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	NA	R
25 months - 6 years	82.22%	R
7-11 years	NA	R
12-19 years	NA	R
Human Papillomavirus Vaccine for Female Adolescents (HPV)	NA	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	NA	R
5-11 Years - 75% Compliance	NA	R
12-18 Years - 50% Compliance	NA	R
12-18 Years - 75% Compliance	NA	R
19-50 Years - 50% Compliance	NA	R
19-50 Years - 75% Compliance	NA	R
51-64 Years - 50% Compliance	NA	R
51-64 Years - 75% Compliance	NA	R
Total - 50% Compliance	NA	R
Total - 75% Compliance	NA	R

ABHNJ HEDIS 2016 Performance Measure	Rate	Status
Annual Dental Visit (ADV)		
Total - 2-3 Years	NA	R
Total - 4-6 Years	NA	R
Total - 7-10 Years	42.86%	R
Total - 11-14 Years	NA	R
Total - 15-18 Years	NA	R
Total - 19-20 Years	NA	R
Total - Total	29.73%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
< 1 Year - Total Medicaid	544.29	R
1-9 Years - Total Medicaid	211.70	R
10-19 Years - Total Medicaid	143.39	R
20-44 Years - Total Medicaid	170.11	R
45-64 Years - Total Medicaid	285.37	R
65-74 Years - Total Medicaid	369.96	R
75-84 Years - Total Medicaid	573.80	R
85+ Years - Total Medicaid	610.81	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	221.91	R
< 1 Year - Dual-Eligibles	NA	R
1-9 Years - Dual-Eligibles	NA	R
10-19 Years - Dual-Eligibles	NA	R
20-44 Years - Dual-Eligibles	149.43	R
45-64 Years - Dual-Eligibles	272.30	R
65-74 Years - Dual-Eligibles	221.12	R
75-84 Years - Dual-Eligibles	392.52	R
85+ Years - Dual-Eligibles	0.00	R
Unknown - Dual-Eligibles	NA	R
Total - Dual-Eligibles	247.25	R
< 1 Year - Disabled	605.23	R
1-9 Years - Disabled	126.35	R
10-19 Years - Disabled	136.99	R
20-44 Years - Disabled	226.32	R
45-64 Years - Disabled	352.09	R

ABHNJ HEDIS 2016 Performance Measure	Rate	Status
65-74 Years - Disabled	392.16	R
75-84 Years - Disabled	571.43	R
85+ Years - Disabled	434.74	R
Unknown - Disabled	NA	R
Total - Disabled	304.98	R
< 1 Year - Other Low Income	543.84	R
1-9 Years - Other Low Income	213.42	R
10-19 Years - Other Low Income	143.52	R
20-44 Years - Other Low Income	169.52	R
45-64 Years - Other Low Income	283.89	R
65-74 Years - Other Low Income	404.74	R
75-84 Years - Other Low Income	628.81	R
85+ Years - Other Low Income	768.60	R
Unknown - Other Low Income	NA	R
Total - Other Low Income	219.84	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	89.55	R
Total - 1-9 Years	46.39	R
Total - 10-19 Years	37.45	R
Total - 20-44 Years	72.80	R
Total - 45-64 Years	56.39	R
Total - 65-74 Years	32.51	R
Total - 75-84 Years	15.06	R
Total - 85+ Years	27.03	R
Total - Unknown Years	NA	R
Total - Total Years	60.92	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	NA	R
Dual Eligibles - 20-44 Years	22.99	R
Dual Eligibles - 45-64 Years	18.78	R
Dual Eligibles - 65-74 Years	33.00	R
Dual Eligibles - 75-84 Years	28.04	R
Dual Eligibles - 85+ Years	0.00	R

ABHNJ HEDIS 2016 Performance Measure	Rate	Status
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	26.10	R
Disabled - <1 Years	78.95	R
Disabled - 1-9 Years	97.47	R
Disabled - 10-19 Years	68.49	R
Disabled - 20-44 Years	291.23	R
Disabled - 45-64 Years	196.14	R
Disabled - 65-74 Years	50.98	R
Disabled - 75-84 Years	10.2	R
Disabled - 85+ Years	21.47	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	143.87	R
Other Low Income - <1 Years	89.63	R
Other Low Income - 1-9 Years	45.36	R
Other Low Income - 10-19 Years	36.82	R
Other Low Income - 20-44 Years	70.43	R
Other Low Income - 45-64 Years	53.38	R
Other Low Income - 65-74 Years	22.66	R
Other Low Income - 75-84 Years	13.85	R
Other Low Income - 85+ Years	33.06	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	711.03	R

[1] HbA1c Poor Control is an inverted measure. Lower rates indicate better performance.

[2] This measure is only applicable for MLTSS and DDD members.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

ABHNJ NJ-Specific 2016 Performance Measures

ABHNJ NJ-Specific 2016 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	54.75%	R
Total Medicaid - 45-64 years	65.12%	R
Total Medicaid - 65+ years	68.18%	R
Total Medicaid - Total	59.30%	R
Dual Eligibles - 20-44 years	NA	R
Dual Eligibles - 45-64 years	50.00%	R
Dual Eligibles - 65+ years	33.33%	R
Dual Eligibles - Total	40.00%	R
Disabled - 20-44 years	66.67%	R
Disabled - 45-64 years	70.00%	R
Disabled - 65+ years	73.68%	R
Disabled - Total	71.05%	R
Other Low Income - 20-44 years	54.33%	R
Other Low Income - 45-64 years	65.00%	R
Other Low Income - 65+ years	NA	R
Other Low Income - Total	58.45%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	72.73%	R
Total Medicaid - 25 months - 6 years	82.22%	R
Total Medicaid - 7-11 years	NA	R
Total Medicaid - 12-19 years	NA	R
Total Medicaid – 12 months-19 years	79.10%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	NA	R
Dual Eligibles - 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	NA	R
Disabled - 12-24 months	NA	R
Disabled - 25 months - 6 years	0.00%	R
Disabled - 7-11 years	NA	R
Disabled - 12-19 years	NA	R
Total Disabled – 12 months-19 years	0.00%	R
Other Low Income - 12-24 months	72.73%	R

ABHNJ NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income - 25 months - 6 years	84.09%	R
Other Low Income - 7-11 years	NA	R
Other Low Income - 12-19 years	NA	R
Total Other Low Income – 12 months-19 years	80.30%	R
Preventive Dental Visit		
Total - 2-3 Years	25.00%	R
Total - 4-6 Years	17.24%	R
Total - 7-10 Years	42.86%	R
Total - 11-14 Years	36.36%	R
Total - 15-18 Years	35.71%	R
Total - 19-21 Years	2.86%	R
Total - 22-34 Years	21.51%	R
Total - 35-64 Years	21.37%	R
Total - 65+ Years	13.64%	R
Total - Total	22.43%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	NA	R
Dual Eligibles - 22-34 Years	NA	R
Dual Eligibles - 35-64 Years	0.00%	R
Dual Eligibles - 65+ Years	0.00%	R
Dual Eligibles - Total	0.00%	R
Disabled - 2-3 Years	NA	R
Disabled - 4-6 Years	0.00%	R
Disabled - 7-10 Years	66.67%	R
Disabled - 11-14 Years	50.00%	R
Disabled - 15-18 Years	NA	R
Disabled - 19-21 Years	0.00%	R
Disabled - 22-34 Years	20.00%	R
Disabled - 35-64 Years	7.14%	R
Disabled - 65+ Years	15.79%	R
Disabled - Total	17.39%	R

ABHNJ NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income - 2-3 Years	25.00%	R
Other Low Income - 4-6 Years	17.86%	R
Other Low Income - 7-10 Years	40.63%	R
Other Low Income - 11-14 Years	35.00%	R
Other Low Income - 15-18 Years	35.71%	R
Other Low Income - 19-21 Years	3.03%	R
Other Low Income - 22-34 Years	21.56%	R
Other Low Income - 35-64 Years	22.48%	R
Other Low Income - 65+ Years	NA	R
Other Low Income - Total	23.06%	R

NA – No members in denominator

ABHNJ HEDIS 2017 Performance Measures

ABHNJ HEDIS 2017 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	41.35%	R
Combination 3	33.65%	R
Combination 9	14.42%	R
Lead Screening in Children (LSC)	47.12%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	45.26%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	67.13%	R
Adolescent Well-Care Visits (AWC)	42.13%	R
Breast Cancer Screening (BCS)	NA	R
Cervical Cancer Screening (CCS)	27.78%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	81.40%	R
HbA1c Poor Control (>9.0%)[1]	52.17%	R
HbA1c Control (<8.0%)	40.34%	R
HbA1c Control (<7.0%) for a Selected Population	23.49%	R
Eye Exam	25.12%	R
Medical Attention for Nephropathy	89.61%	R
Blood Pressure Controlled <140/90 mm Hg	42.75%	R
Controlling High Blood Pressure (CBP)	36.73%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	77.62%	R
Postpartum Care	56.64%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	49.30%	R
Immunizations For Adolescents (IMA)		
Meningococcal	50.67%	R
Tdap/Td	73.33%	R
HPV[3]	8.00%	R
Combination 1	50.67%	R
Combination 2	8.00%	R
Appropriate testing for children with pharyngitis (CWP)	68.63%	R
Chlamydia Screening (CHL)		
16-20	52.29%	R

ABHNJ HEDIS 2017 Performance Measure	Rate	Status
21-24	61.98%	R
Total	58.47%	R
BMI assessment for children/adolescents (WCC)		
BMI percentile - 3-11 Years	63.53%	R
BMI percentile - 12-17 Years	66.87%	R
BMI percentile - Total	64.81%	R
Counseling for Nutrition - 3-11 Years	60.90%	R
Counseling for Nutrition - 12-17 Years	69.88%	R
Counseling for Nutrition - Total	64.35%	R
Counseling for Physical Activity - 3-11 Years	51.50%	R
Counseling for Physical Activity - 12-17 Years	62.05%	R
Counseling for Physical Activity - Total	55.56%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	NA	R
Continuation and Maintenance Phase	NA	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[2]		
30 Day Followup	35.71%	R
7 Day Followup	28.57%	R
Adult BMI Assessment (ABA)	60.54%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	81.08%	R
Digoxin	NA	R
Diuretics	79.77%	R
Total	80.43%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	88.89%	R
25 months - 6 years	78.74%	R
7-11 years	NA	R
12-19 years	77.42%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	NA	R

ABHNJ HEDIS 2017 Performance Measure	Rate	Status
12-18 Years - 50% Compliance	NA	R
19-50 Years - 50% Compliance	NA	R
51-64 Years - 50% Compliance	NA	R
Total - 50% Compliance	NA	R
5-11 Years - 75% Compliance	NA	R
12-18 Years - 75% Compliance	NA	R
19-50 Years - 75% Compliance	NA	R
51-64 Years - 75% Compliance	NA	R
Total - 75% Compliance	NA	R
Annual Dental Visit (ADV)		
Total - 2-3 Years	22.57%	R
Total - 4-6 Years	42.04%	R
Total - 7-10 Years	45.64%	R
Total - 11-14 Years	41.88%	R
Total - 15-18 Years	38.88%	R
Total - 19-20 Years	27.65%	R
Total - Total	38.57%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
Total Medicaid - < 1 Year	648.49	R
Total Medicaid - 1-9 Years	271.98	R
Total Medicaid - 10-19 Years	166.20	R
Total Medicaid - 20-44 Years	180.71	R
Total Medicaid - 45-64 Years	300.45	R
Total Medicaid - 65-74 Years	374.76	R
Total Medicaid - 75-84 Years	256.75	R
Total Medicaid - 85+ Years	287.36	R
Total Medicaid - Unknown	NA	R
Total Medicaid - Total	241.37	R
Dual-Eligibles - < 1 Year	NA	R
Dual-Eligibles - 1-9 Years	NA	R
Dual-Eligibles - 10-19 Years	0.00	R
Dual-Eligibles - 20-44 Years	96.87	R
Dual-Eligibles - 45-64 Years	350.79	R
Dual-Eligibles - 65-74 Years	213.46	R
Dual-Eligibles - 75-84 Years	117.51	R

ABHNJ HEDIS 2017 Performance Measure	Rate	Status
Dual-Eligibles - 85+ Years	130.77	R
Dual-Eligibles - Unknown	NA	R
Dual-Eligibles - Total	211.50	R
Disabled - < 1 Year	392.52	R
Disabled - 1-9 Years	322.22	R
Disabled - 10-19 Years	155.76	R
Disabled - 20-44 Years	326.84	R
Disabled - 45-64 Years	565.23	R
Disabled - 65-74 Years	471.92	R
Disabled - 75-84 Years	328.78	R
Disabled - 85+ Years	387.85	R
Disabled - Unknown	NA	R
Disabled - Total	405.33	R
Other Low Income - < 1 Year	651.15	R
Other Low Income - 1-9 Years	270.94	R
Other Low Income - 10-19 Years	166.57	R
Other Low Income - 20-44 Years	177.70	R
Other Low Income - 45-64 Years	284.18	R
Other Low Income - 65-74 Years	666.67	R
Other Low Income - 75-84 Years	NA	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown	NA	R
Other Low Income - Total	234.57	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	96.74	R
Total - 1-9 Years	50.58	R
Total - 10-19 Years	33.97	R
Total - 20-44 Years	69.04	R
Total - 45-64 Years	53.92	R
Total - 65-74 Years	20.24	R
Total - 75-84 Years	22.08	R
Total - 85+ Years	22.99	R
Total - Unknown Years	NA	R
Total - Total Years	58.16	R
Dual Eligibles - <1 Years	NA	R

ABHNJ HEDIS 2017 Performance Measure	Rate	Status
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	0.00	R
Dual Eligibles - 20-44 Years	34.19	R
Dual Eligibles - 45-64 Years	22.22	R
Dual Eligibles - 65-74 Years	7.39	R
Dual Eligibles - 75-84 Years	14.39	R
Dual Eligibles - 85+ Years	7.69	R
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	15.29	R
Disabled - <1 Years	56.07	R
Disabled - 1-9 Years	62.96	R
Disabled - 10-19 Years	25.68	R
Disabled - 20-44 Years	158.76	R
Disabled - 45-64 Years	133.70	R
Disabled - 65-74 Years	26.77	R
Disabled - 75-84 Years	26.05	R
Disabled - 85+ Years	32.71	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	90.95	R
Other Low Income - <1 Years	97.17	R
Other Low Income - 1-9 Years	50.33	R
Other Low Income - 10-19 Years	34.26	R
Other Low Income - 20-44 Years	67.14	R
Other Low Income - 45-64 Years	49.58	R
Other Low Income - 65-74 Years	102.56	R
Other Low Income - 75-84 Years	NA	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	57.22	R

[1] HbA1c Poor Control is an inverted measure. Higher rates for HbA1c Poor Control indicate poorer performance.

[2] Follow-up After Hospitalization and Follow-Up After Emergency Department Visit for Mental Illness are only applicable to members who receive a behavioral health benefit. This is limited to the MLTSS and DDD members.

[3] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others).

ABHNJ NJ-Specific 2017 Performance Measures

ABHNJ NJ-Specific 2017 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	50.31%	R
Total Medicaid - 45-64 years	63.46%	R
Total Medicaid - 65+ years	66.84%	R
Total Medicaid - Total	55.47%	R
Dual Eligibles - 20-44 years	NA	R
Dual Eligibles - 45-64 years	NA	R
Dual Eligibles - 65+ years	43.08%	R
Dual Eligibles - Total	47.17%	R
Disabled - 20-44 years	65.05%	R
Disabled - 45-64 years	78.57%	R
Disabled - 65+ years	78.81%	R
Disabled - Total	74.93%	R
Other Low Income - 20-44 years	49.97%	R
Other Low Income - 45-64 years	62.38%	R
Other Low Income - 65+ years	NA	R
Other Low Income - Total	54.39%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	88.89%	R
Total Medicaid - 25 months - 6 years	78.74%	R
Total Medicaid - 7-11 years	NA	R
Total Medicaid - 12-19 years	77.42%	R
Total Medicaid – 12 months-19 years	81.94%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	NA	R
Dual Eligibles - 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	NA	R
Disabled - 12-24 months	NA	R
Disabled - 25 months - 6 years	NA	R
Disabled - 7-11 years	NA	R
Disabled - 12-19 years	NA	R
Total Disabled – 12 months-19 years	76.67%	R
Other Low Income - 12-24 months	88.92%	R

ABHNJ NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income - 25 months - 6 years	78.85%	R
Other Low Income - 7-11 years	NA	R
Other Low Income - 12-19 years	76.67%	R
Total Other Low Income – 12 months-19 years	82.08%	R
Preventive Dental Visit		
Total - 2-3 Years	21.94%	R
Total - 4-6 Years	41.04%	R
Total - 7-10 Years	44.03%	R
Total - 11-14 Years	38.16%	R
Total - 15-18 Years	35.51%	R
Total - 19-21 Years	22.36%	R
Total - 22-34 Years	17.67%	R
Total - 35-64 Years	21.79%	R
Total - 65+ Years	19.81%	R
Total - Total	24.70%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	NA	R
Dual Eligibles - 22-34 Years	NA	R
Dual Eligibles - 35-64 Years	32.00%	R
Dual Eligibles - 65+ Years	23.33%	R
Dual Eligibles - Total	25.32%	R
Disabled - 2-3 Years	NA	R
Disabled - 4-6 Years	NA	R
Disabled - 7-10 Years	NA	R
Disabled - 11-14 Years	NA	R
Disabled - 15-18 Years	NA	R
Disabled - 19-21 Years	NA	R
Disabled - 22-34 Years	27.66%	R
Disabled - 35-64 Years	27.27%	R
Disabled - 65+ Years	17.80%	R
Disabled - Total	24.28%	R

ABHNJ NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income - 2-3 Years	22.04%	R
Other Low Income - 4-6 Years	41.49%	R
Other Low Income - 7-10 Years	44.70%	R
Other Low Income - 11-14 Years	38.09%	R
Other Low Income - 15-18 Years	35.56%	R
Other Low Income - 19-21 Years	23.79%	R
Other Low Income - 22-34 Years	17.47%	R
Other Low Income - 35-64 Years	21.31%	R
Other Low Income - 65+ Years	NA	R
Other Low Income - Total	24.71%	R

NA – Insufficient membership to report a rate (<30 members in denominator).

ABHNJ Quality Improvement Projects

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

QIP 1: June 2016 Project Baseline Update Review

AETNA BETTER HEALTH OF NEW JERSEY - SUMMARY SCORING				
REDUCTION IN FALLS AMONG HOME AND COMMUNITY-BASED MEMBERS IN MLTSS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	PM	50	5%	2.5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	37.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT –Current available points 60			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: October 2016 Project Year 1 Update (1) Review

AETNA BETTER HEALTH OF NEW JERSEY - SUMMARY SCORING				
REDUCTION IN FALLS AMONG HOME AND COMMUNITY-BASED MEMBERS IN MLTSS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: June 2017 Project Year 1 Update (2) Review

AETNA BETTER HEALTH OF NEW JERSEY - SUMMARY SCORING				
REDUCTION IN FALLS AMONG HOME AND COMMUNITY-BASED MEMBERS IN MLTSS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	55
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: October 2017 Project Year 2 Update (1) Review

AETNA BETTER HEALTH OF NEW JERSEY - SUMMARY SCORING				
REDUCTION IN FALLS AMONG HOME AND COMMUNITY-BASED MEMBERS IN MLTSS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

ABHNJ QIP 2: Improving the Rate of Developmental Screening and Rate of Referral to Early Intervention Services for Children Aged 0-3 Years

QIP 2: September 2017 Project Proposal Review

AETNA BETTER HEALTH OF NEW JERSEY - SUMMARY SCORING				
IMPROVING THE RATE OF DEVELOPMENTAL SCREENING AND RATE OF REFERRAL TO EARLY INTERVENTION SERVICES FOR CHILDREN AGED 0-3 YEARS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	MET	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PARTIAL MET	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PARTIAL MET	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	PARTIAL MET	50	10%	5
Review Element 6 - Data Collection Procedures	PARTIAL MET	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	MET	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full (MET) = 100pts, Partial (PARTIAL MET) = 50pts, Non-Compliance (NOT MET) = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	65-80	1	Requirements MET - Comments, Suggestions
	50-64	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

ABHNJ Care Management Audits

ABHNJ Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2015 (n=100)	2016 (n=100)	% Point Change	2015 (n=9)	2016 (n=18)	% Point Change	2015 (n=15)	2016 (n=27)	% Point Change
Identification	61%	74%	+13	100%	100%	0	100%	100%	0
Outreach	74%	88%	+14	100%	97%	-3	82%	100%	+18
Preventive Services	29%	67%	+38	65%	88%	+23	80%	98%	+18
Continuity of Care	94%	99%	+5	91%	95%	+4	100%	100%	0
Coordination of Services	97%	100%	+3	100%	100%	0	100%	100%	0

ABHNJ MLTSS HCBS Care Management Audits: July 2015–June 2017

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
#8. Initial Plan of Care established within 30 days of enrollment into MLTSS/HCBS.[1]	Group A&B										
	Group C				68	28	41.2%	59	18	30.5%	-10.7
	Group D				11	4	36.4%	41	10	24.4%	-12.0
	Group E										
	Total				79	32	40.5%	100	28	28.0%	-12.5
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group A&B										
	Group C				2	1	50.0%	2	2	100.0%	50.0
	Group D				0	0	0.0%	3	0	N/A	N/A
	Group E							4	2	50.0%	
	Total				2	1	50.0%	9	4	44.4%	-5.6
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group A&B										
	Group C				4	0	0.0%	2	0	N/A	N/A
	Group D				3	0	0.0%	1	0	N/A	N/A
	Group E							4	1	25.0%	
	Total				7	0	0.0%	7	1	14.3%	14.3
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	Group A&B										
	Group C				42	40	95.2%	46	24	52.2%	-43.0
	Group D				4	3	75.0%	35	23	65.7%	-9.3
	Group E							19	10	52.6%	
	Total				46	43	93.5%	100	57	57.0%	-36.5
#11. Plans of Care developed using "person-centered principles" [5]	Group A&B										
	Group C				68	3	4.4%	46	21	45.7%	41.3
	Group D				11	1	9.1%	35	19	54.3%	45.2
	Group E							19	9	47.4%	
	Total				79	4	5.1%	100	49	49.0%	43.9
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group A&B										
	Group C				48	17	35.4%	31	17	54.8%	19.4
	Group D				8	1	12.5%	35	15	42.9%	30.4
	Group E							16	11	68.8%	
	Total				56	18	32.1%	82	43	52.4%	20.3
#16. Member training on identifying/reporting critical incidents	Group A&B										
	Group C				68	7	10.3%	46	27	58.7%	48.4
	Group D				11	0	0.0%	35	20	57.1%	57.1

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
	Group E							19	16	84.2%	
	Total				79	7	8.9%	100	63	63.0%	54.1

[1] From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.

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

[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.

[6]Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017.

In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing

Group A & B – Current Members converted to MLTSS on 7/1/2014. These members were only included in the initial review period.

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

AGNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

AGNJ 2016 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year	Subject to Review[1]	Subject to Review and Met[2]	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Access	8	5	3	1	6	2	0	75%	2	0	0
Quality Assessment and Performance Improvement	10	9	0	0	9	0	1	100%	0	0	0
Quality Management	13	8	5	3	11	2	0	85%	2	2	0
Efforts to Reduce Healthcare Disparities	4	0	4	2	2	2	0	50%	2	1	0
Committee Structure	9	6	4	4	9	0	0	100%	0	2	0
Programs for the Elderly and Disabled	44	40	4	4	44	0	0	100%	0	3	0
Provider Training and Performance	11	7	4	3	10	1	0	91%	1	2	0
Satisfaction	4	3	0	0	3	0	1	100%	0	0	0
Enrollee Rights and Responsibilities	8	7	3	3	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	32	14	11	34	3	0	92%	1	2	2
Credentialing and Recredentialing	10	8	3	2	9	1	0	90%	1	0	0
Utilization Management	22	20	3	2	21	1	0	95%	1	0	0
Administration and Operations	13	11	3	3	13	0	0	100%	0	1	0
Management Information Systems	18	13	7	6	17	1	0	94%	1	3	0
TOTAL	**211**	**169**	**57**	**44**	**196**	**13**	**2**	**94%**	**11**	**16**	**2**

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

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

[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. 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 number of total elements minus N/A elements. The numerator is the number of *Total Met* elements.

AGNJ 2017 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	8	6	8	6	2	0	75%	2	0	0
Quality Assessment and Performance Improvement	10	9	10	10	0	0	100%	0	0	0
Quality Management	17	11	17	16	1	0	94%	1	1	0
Efforts to Reduce Healthcare Disparities	5	2	5	5	0	0	100%	0	2	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	44	43	0	1	100%	0	0	0
Provider Training and Performance	11	10	11	11	0	0	100%	0	1	0
Satisfaction	4	3	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	34	37	32	5	0	86%	1	2	4
Credentialing and Recredentialing	10	9	10	10	0	0	100%	0	1	0
Utilization Management	22	21	22	19	3	0	86%	1	0	2
Administration and Operations	13	13	13	12	1	0	92%	0	0	1
Management Information Systems	18	17	18	18	0	0	100%	0	1	0
TOTAL	**216**	**196**	**216**	**203**	**12**	**1**	**94%**	**5**	**8**	**7**

[1] A total of 57 elements were reviewed in the previous review period; of these 57, 44 were *Met*. All other elements (152) that are *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

AGNJ Performance Measures

AGNJ HEDIS 2016 Performance Measures

AGNJ HEDIS 2016 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	73.78%	R
Combination 3	67.05%	R
Lead Screening in Children (LSC)	75.64%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	68.84%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	80.89%	R
Adolescent Well-Care Visits (AWC)	65.97%	R
Breast Cancer Screening (BCS)	49.31%	R
Cervical Cancer Screening (CCS)	53.97%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	85.26%	R
HbA1c Poor Control (>9.0%)[1]	38.02%	R
HbA1c Control (<8.0%)	52.09%	R
HbA1c Control (<7.0%) for a Selected Population	38.79%	R
Eye Exam	51.93%	R
Medical Attention for Nephropathy	92.29%	R
Blood Pressure Controlled <140/90 mm Hg	49.25%	R
Controlling High Blood Pressure (CBP)	66.36%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	85.48%	R
Postpartum Care	55.50%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	64.87%	R
Immunizations For Adolescents (IMA)		
Meningococcal	83.10%	R
Tdap/Td	91.67%	R
Combination 1	82.64%	R
Appropriate testing for children with pharyngitis (CWP)	76.80%	R
Chlamydia Screening (CHL)		
16-20	57.51%	R
21-24	66.01%	R

AGNJ HEDIS 2016 Performance Measure	Rate	Status
Total	61.45%	R
BMI assessment for children/adolescents (WCC)		
3-11	87.36%	R
12-17	85.96%	R
Total	86.81%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	32.31%	R
Continuation and Maintenance Phase	34.43%	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	57.63%	R
7 Day Followup	35.59%	R
Adult BMI Assessment (ABA)	86.08%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	89.16%	R
Digoxin	59.26%	R
Diuretics	88.53%	R
Total	88.74%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	95.68%	R
25 months - 6 years	91.88%	R
7-11 years	93.05%	R
12-19 years	90.11%	R
Human Papillomavirus Vaccine for Female Adolescents (HPV)	20.83%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	48.63%	R
5-11 Years - 75% Compliance	23.97%	R
12-18 Years - 50% Compliance	48.47%	R
12-18 Years - 75% Compliance	22.01%	R
19-50 Years - 50% Compliance	58.06%	R
19-50 Years - 75% Compliance	35.78%	R
51-64 Years - 50% Compliance	63.10%	R
51-64 Years - 75% Compliance	44.64%	R
Total - 50% Compliance	52.91%	R
Total - 75% Compliance	29.17%	R

AGNJ HEDIS 2016 Performance Measure	Rate	Status
Annual Dental Visit (ADV)		
Total – 2-3 Years	43.40%	R
Total – 4-6 Years	62.77%	R
Total – 7-10 Years	67.12%	R
Total – 11-14 Years	63.39%	R
Total – 15-18 Years	53.57%	R
Total – 19-20 Years	37.71%	R
Total – Total	58.56%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
< 1 Year - Total Medicaid	738.75	R
1-9 Years - Total Medicaid	332.15	R
10-19 Years - Total Medicaid	249.32	R
20-44 Years - Total Medicaid	271.88	R
45-64 Years - Total Medicaid	488.03	R
65-74 Years - Total Medicaid	625.61	R
75-84 Years - Total Medicaid	522.77	R
85+ Years - Total Medicaid	469.35	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	335.97	R
< 1 Year - Dual-Eligibles	NA	R
1-9 Years - Dual-Eligibles	NA	R
10-19 Years - Dual-Eligibles	NA	R
20-44 Years - Dual-Eligibles	NA	R
45-64 Years - Dual-Eligibles	NA	R
65-74 Years - Dual-Eligibles	NA	R
75-84 Years - Dual-Eligibles	NA	R
85+ Years - Dual-Eligibles	NA	R
Unknown - Dual-Eligibles	NA	R
Total - Dual-Eligibles	NA	R
< 1 Year - Disabled	681.61	R
1-9 Years - Disabled	428.01	R
10-19 Years - Disabled	258.84	R
20-44 Years - Disabled	289.37	R
45-64 Years - Disabled	714.60	R

AGNJ HEDIS 2016 Performance Measure	Rate	Status
65-74 Years - Disabled	628.51	R
75-84 Years - Disabled	522.62	R
85+ Years - Disabled	469.35	R
Unknown - Disabled	NA	R
Total - Disabled	478.32	R
< 1 Year - Other Low Income	739.34	R
1-9 Years - Other Low Income	329.76	R
10-19 Years - Other Low Income	248.78	R
20-44 Years - Other Low Income	270.44	R
45-64 Years - Other Low Income	446.38	R
65-74 Years - Other Low Income	482.76	R
75-84 Years - Other Low Income	600.00	R
85+ Years - Other Low Income	NA	R
Unknown - Other Low Income	NA	R
Total - Other Low Income	323.79	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	91.29	R
Total - 1-9 Years	49.73	R
Total - 10-19 Years	35.71	R
Total - 20-44 Years	75.97	R
Total - 45-64 Years	62.68	R
Total - 65-74 Years	36.59	R
Total - 75-84 Years	29.06	R
Total - 85+ Years	24.35	R
Total - Unknown Years	NA	R
Total - Total Years	57.94	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	NA	R
Dual Eligibles - 20-44 Years	NA	R
Dual Eligibles - 45-64 Years	NA	R
Dual Eligibles - 65-74 Years	NA	R
Dual Eligibles - 75-84 Years	NA	R
Dual Eligibles - 85+ Years	NA	R

AGNJ HEDIS 2016 Performance Measure	Rate	Status
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	NA	R
Disabled - <1 Years	109.74	R
Disabled - 1-9 Years	68.62	R
Disabled - 10-19 Years	52.26	R
Disabled - 20-44 Years	95.99	R
Disabled - 45-64 Years	114.38	R
Disabled - 65-74 Years	37.03	R
Disabled - 75-84 Years	28.98	R
Disabled - 85+ Years	24.35	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	86.64	R
Other Low Income - <1 Years	91.10	R
Other Low Income - 1-9 Years	49.26	R
Other Low Income - 10-19 Years	34.77	R
Other Low Income - 20-44 Years	74.32	R
Other Low Income - 45-64 Years	53.17	R
Other Low Income - 65-74 Years	14.78	R
Other Low Income - 75-84 Years	66.67	R
Other Low Income - 85+ Years	NA	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	55.49	R

[1] HbA1c Poor Control is an inverted measure. Lower rates indicate better performance.

[2] This measure is only applicable for MLTSS and DDD members.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

AGNJ NJ-Specific 2016 Performance Measures

AGNJ NJ-Specific 2016 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid – 20-44 years	72.13%	R
Total Medicaid – 45-64 years	80.94%	R
Total Medicaid – 65+ years	78.40%	R
Total Medicaid – Total	75.67%	R
Dual Eligibles – 20-44 years	NA	R
Dual Eligibles – 45-64 years	NA	R
Dual Eligibles – 65+ years	NA	R
Dual Eligibles – Total	NA	R
Disabled – 20-44 years	65.97%	R
Disabled – 45-64 years	85.83%	R
Disabled – 65+ years	78.53%	R
Disabled – Total	76.91%	R
Other Low Income – 20-44 years	72.95%	R
Other Low Income – 45-64 years	79.62%	R
Other Low Income – 65+ years	68.75%	R
Other Low Income – Total	75.41%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid – 12-24 months	95.68%	R
Total Medicaid – 25 months – 6 years	91.88%	R
Total Medicaid – 7-11 years	93.05%	R
Total Medicaid – 12-19 years	90.11%	R
Total Medicaid – 12 months-19 years	91.81%	R
Dual Eligibles – 12-24 months	NA	R
Dual Eligibles – 25 months – 6 years	NA	R
Dual Eligibles – 7-11 years	NA	R
Dual Eligibles – 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	NA	R
Disabled – 12-24 months	82.76%	R
Disabled – 25 months – 6 years	88.31%	R
Disabled – 7-11 years	91.49%	R
Disabled – 12-19 years	84.74%	R

AGNJ NJ-Specific 2016 Performance Measure	Rate	Status
Total Disabled – 12 months-19 years	87.01%	R
Other Low Income – 12-24 months	95.89%	R
Other Low Income – 25 months – 6 years	91.97%	R
Other Low Income – 7-11 years	93.12%	R
Other Low Income – 12-19 years	90.52%	R
Total Other Low Income – 12 months-19 years	92.03%	R
Preventive Dental Visit		
Total – 2-3 Years	42.55%	R
Total – 4-6 Years	60.57%	R
Total – 7-10 Years	64.40%	R
Total – 11-14 Years	59.49%	R
Total – 15-18 Years	48.37%	R
Total – 19-21 Years	31.62%	R
Total – 22-34 Years	28.52%	R
Total – 35-64 Years	29.94%	R
Total – 65+ Years	18.53%	R
Total – Total	43.47%	R
Dual Eligibles – 2-3 Years	NA	R
Dual Eligibles – 4-6 Years	NA	R
Dual Eligibles – 7-10 Years	NA	R
Dual Eligibles – 11-14 Years	NA	R
Dual Eligibles – 15-18 Years	NA	R
Dual Eligibles – 19-21 Years	NA	R
Dual Eligibles – 22-34 Years	NA	R
Dual Eligibles – 35-64 Years	NA	R
Dual Eligibles – 65+ Years	NA	R
Dual Eligibles – Total	NA	R
Disabled – 2-3 Years	29.58%	R
Disabled – 4-6 Years	50.15%	R
Disabled – 7-10 Years	50.83%	R
Disabled – 11-14 Years	49.08%	R
Disabled – 15-18 Years	36.08%	R
Disabled – 19-21 Years	23.99%	R
Disabled – 22-34 Years	23.84%	R

AGNJ NJ-Specific 2016 Performance Measure	Rate	Status
Disabled – 35-64 Years	24.36%	R
Disabled – 65+ Years	18.45%	R
Disabled – Total	27.99%	R
Other Low Income – 2-3 Years	42.78%	R
Other Low Income – 4-6 Years	60.86%	R
Other Low Income – 7-10 Years	64.94%	R
Other Low Income – 11-14 Years	60.10%	R
Other Low Income – 15-18 Years	49.18%	R
Other Low Income – 19-21 Years	32.91%	R
Other Low Income – 22-34 Years	29.20%	R
Other Low Income – 35-64 Years	31.09%	R
Other Low Income – 65+ Years	25.00%	R
Other Low Income – Total	45.28%	R

NA – No members in denominator

AGNJ HEDIS 2017 Performance Measures

AGNJ HEDIS 2017 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	75.69%	R
Combination 3	67.82%	R
Combination 9	35.42%	R
Lead Screening in Children (LSC)	69.91%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	61.64%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	79.23%	R
Adolescent Well-Care Visits (AWC)	58.99%	R
Breast Cancer Screening (BCS)	52.11%	R
Cervical Cancer Screening (CCS)	57.31%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	87.15%	R
HbA1c Poor Control (>9.0%)[1]	31.77%	R
HbA1c Control (<8.0%)	58.51%	R
HbA1c Control (<7.0%) for a Selected Population	41.13%	R
Eye Exam	54.51%	R
Medical Attention for Nephropathy	92.19%	R
Blood Pressure Controlled <140/90 mm Hg	41.84%	R
Controlling High Blood Pressure (CBP)	60.42%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	85.35%	R
Postpartum Care	68.14%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	72.09%	R
Immunizations For Adolescents (IMA)		
Meningococcal	81.02%	R
Tdap/Td	90.28%	R
HPV[3]	16.67%	R
Combination 1	78.70%	R
Combination 2	15.28%	R
Appropriate testing for children with pharyngitis (CWP)	81.47%	R
Chlamydia Screening (CHL)		
16-20	58.55%	R

AGNJ HEDIS 2017 Performance Measure	Rate	Status
21-24	69.46%	R
Total	63.70%	R
BMI assessment for children/adolescents (WCC)		
BMI percentile - 3-11 Years	88.52%	R
BMI percentile - 12-17 Years	85.80%	R
BMI percentile - Total	87.50%	R
Counseling for Nutrition - 3-11 Years	85.93%	R
Counseling for Nutrition - 12-17 Years	82.72%	R
Counseling for Nutrition - Total	84.72%	R
Counseling for Physical Activity - 3-11 Years	71.85%	R
Counseling for Physical Activity - 12-17 Years	79.63%	R
Counseling for Physical Activity - Total	74.77%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	32.90%	R
Continuation and Maintenance Phase	39.02%	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	47.06%	R
7 Day Followup	26.47%	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[2]		
30 Day Followup	52.29%	R
7 Day Followup	41.28%	R
Adult BMI Assessment (ABA)	94.44%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	90.25%	R
Digoxin	60.00%	R
Diuretics	89.31%	R
Total	89.71%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	95.34%	R
25 months - 6 years	91.48%	R
7-11 years	94.42%	R
12-19 years	91.41%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	40.77%	R

AGNJ HEDIS 2017 Performance Measure	Rate	Status
12-18 Years - 50% Compliance	46.56%	R
19-50 Years - 50% Compliance	57.36%	R
51-64 Years - 50% Compliance	66.52%	R
Total - 50% Compliance	51.18%	R
5-11 Years - 75% Compliance	22.54%	R
12-18 Years - 75% Compliance	27.19%	R
19-50 Years - 75% Compliance	30.20%	R
51-64 Years - 75% Compliance	45.25%	R
Total - 75% Compliance	29.59%	R
Annual Dental Visit (ADV)		
Total - 2-3 Years	43.99%	R
Total - 4-6 Years	63.37%	R
Total - 7-10 Years	67.99%	R
Total - 11-14 Years	64.60%	R
Total - 15-18 Years	54.99%	R
Total - 19-20 Years	38.75%	R
Total - Total	59.41%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
Total Medicaid - < 1 Year	764.12	R
Total Medicaid - 1-9 Years	343.05	R
Total Medicaid - 10-19 Years	256.34	R
Total Medicaid - 20-44 Years	284.76	R
Total Medicaid - 45-64 Years	508.44	R
Total Medicaid - 65-74 Years	690.82	R
Total Medicaid - 75-84 Years	563.79	R
Total Medicaid - 85+ Years	489.86	R
Total Medicaid - Unknown	NA	R
Total Medicaid - Total	349.28	R
Dual-Eligibles - < 1 Year		NR
Dual-Eligibles - 1-9 Years		NR
Dual-Eligibles - 10-19 Years		NR
Dual-Eligibles - 20-44 Years		NR
Dual-Eligibles - 45-64 Years		NR
Dual-Eligibles - 65-74 Years		NR

AGNJ HEDIS 2017 Performance Measure	Rate	Status
Dual-Eligibles - 75-84 Years		NR
Dual-Eligibles - 85+ Years		NR
Dual-Eligibles - Unknown		NR
Dual-Eligibles - Total		NR
Disabled - < 1 Year	642.16	R
Disabled - 1-9 Years	411.33	R
Disabled - 10-19 Years	255.50	R
Disabled - 20-44 Years	303.16	R
Disabled - 45-64 Years	735.76	R
Disabled - 65-74 Years	693.13	R
Disabled - 75-84 Years	563.22	R
Disabled - 85+ Years	489.86	R
Disabled - Unknown	NA	R
Disabled - Total	492.36	R
Other Low Income - < 1 Year	765.25	R
Other Low Income - 1-9 Years	341.25	R
Other Low Income - 10-19 Years	256.38	R
Other Low Income - 20-44 Years	283.23	R
Other Low Income - 45-64 Years	466.02	R
Other Low Income - 65-74 Years	572.97	R
Other Low Income - 75-84 Years	1,400.00	R
Other Low Income - 85+ Years	NA	R
Other Low Income - Unknown	NA	R
Other Low Income - Total	337.04	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	91.73	R
Total - 1-9 Years	48.80	R
Total - 10-19 Years	34.11	R
Total - 20-44 Years	71.86	R
Total - 45-64 Years	60.55	R
Total - 65-74 Years	36.23	R
Total - 75-84 Years	19.99	R
Total - 85+ Years	26.60	R
Total - Unknown Years	NA	R

AGNJ HEDIS 2017 Performance Measure	Rate	Status
Total - Total Years	55.65	R
Dual Eligibles - <1 Years		NR
Dual Eligibles - 1-9 Years		NR
Dual Eligibles - 10-19 Years		NR
Dual Eligibles - 20-44 Years		NR
Dual Eligibles - 45-64 Years		NR
Dual Eligibles - 65-74 Years		NR
Dual Eligibles - 75-84 Years		NR
Dual Eligibles - 85+ Years		NR
Dual Eligibles - Unknown Years		NR
Dual Eligibles - Total Years		NR
Disabled - <1 Years	91.50	R
Disabled - 1-9 Years	66.61	R
Disabled - 10-19 Years	48.67	R
Disabled - 20-44 Years	86.69	R
Disabled - 45-64 Years	111.10	R
Disabled - 65-74 Years	35.98	R
Disabled - 75-84 Years	19.74	R
Disabled - 85+ Years	26.60	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	81.37	R
Other Low Income - <1 Years	91.73	R
Other Low Income - 1-9 Years	48.33	R
Other Low Income - 10-19 Years	33.30	R
Other Low Income - 20-44 Years	70.62	R
Other Low Income - 45-64 Years	51.12	R
Other Low Income - 65-74 Years	48.65	R
Other Low Income - 75-84 Years	400.00	R
Other Low Income - 85+ Years	NA	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	53.45	R

[1] HbA1c Poor Control is an inverted measure. Higher rates for HbA1c Poor Control indicate poorer performance.

[2] Follow-up After Hospitalization and Follow-Up After Emergency Department Visit for Mental Illness are only applicable to members who receive a behavioral health benefit. This is limited to the MLTSS and DDD members.

[3] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.
NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others).
NR – Not Reportable. The calculated rate was materially biased, or the organization chose not to report the measure.

AGNJ NJ-Specific 2017 Performance Measures

AGNJ NJ-Specific 2017 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid – 20-44 years	70.89%	R
Total Medicaid – 45-64 years	79.76%	R
Total Medicaid – 65+ years	80.64%	R
Total Medicaid – Total	74.52%	R
Dual Eligibles – 20-44 years	NA	R
Dual Eligibles – 45-64 years	NA	R
Dual Eligibles – 65+ years	NA	R
Dual Eligibles – Total	NA	R
Disabled – 20-44 years	67.07%	R
Disabled – 45-64 years	85.85%	R
Disabled – 65+ years	80.76%	R
Disabled – Total	77.65%	R
Other Low Income – 20-44 years	71.36%	R
Other Low Income – 45-64 years	78.28%	R
Other Low Income – 65+ years	NA	R
Other Low Income – Total	73.93%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid – 12-24 months	95.34%	R
Total Medicaid – 25 months – 6 years	91.48%	R
Total Medicaid – 7-11 years	94.42%	R
Total Medicaid – 12-19 years	91.41%	R
Total Medicaid – 12 months-19 years	92.45%	R
Dual Eligibles – 12-24 months	NA	R
Dual Eligibles – 25 months – 6 years	NA	R
Dual Eligibles – 7-11 years	NA	R
Dual Eligibles – 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	NA	R
Disabled – 12-24 months	78.00%	R
Disabled – 25 months – 6 years	87.89%	R
Disabled – 7-11 years	93.62%	R
Disabled – 12-19 years	86.70%	R

AGNJ NJ-Specific 2017 Performance Measure	Rate	Status
Total Disabled – 12 months-19 years	88.56%	R
Other Low Income – 12-24 months	95.58%	R
Other Low Income – 25 months – 6 years	91.56%	R
Other Low Income – 7-11 years	94.45%	R
Other Low Income – 12-19 years	91.74%	R
Total Other Low Income – 12 months-19 years	92.62%	R
Preventive Dental Visit		
Total – 2-3 Years	43.21%	R
Total – 4-6 Years	61.71%	R
Total – 7-10 Years	65.86%	R
Total – 11-14 Years	61.33%	R
Total – 15-18 Years	50.35%	R
Total – 19-21 Years	33.15%	R
Total – 22-34 Years	27.25%	R
Total – 35-64 Years	29.52%	R
Total – 65+ Years	27.41%	R
Total – Total	42.42%	R
Dual Eligibles – 2-3 Years	NA	R
Dual Eligibles – 4-6 Years	NA	R
Dual Eligibles – 7-10 Years	NA	R
Dual Eligibles – 11-14 Years	NA	R
Dual Eligibles – 15-18 Years	NA	R
Dual Eligibles – 19-21 Years	NA	R
Dual Eligibles – 22-34 Years	32.85%	R
Dual Eligibles – 35-64 Years	34.62%	R
Dual Eligibles – 65+ Years	29.00%	R
Dual Eligibles – Total	30.48%	R
Disabled – 2-3 Years	30.28%	R
Disabled – 4-6 Years	57.56%	R
Disabled – 7-10 Years	53.20%	R
Disabled – 11-14 Years	47.78%	R
Disabled – 15-18 Years	39.48%	R
Disabled – 19-21 Years	24.28%	R
Disabled – 22-34 Years	23.00%	R

AGNJ NJ-Specific 2017 Performance Measure	Rate	Status
Disabled – 35-64 Years	23.73%	R
Disabled – 65+ Years	17.94%	R
Disabled – Total	27.89%	R
Other Low Income – 2-3 Years	43.46%	R
Other Low Income – 4-6 Years	61.82%	R
Other Low Income – 7-10 Years	66.39%	R
Other Low Income – 11-14 Years	62.06%	R
Other Low Income – 15-18 Years	51.05%	R
Other Low Income – 19-21 Years	34.40%	R
Other Low Income – 22-34 Years	27.73%	R
Other Low Income – 35-64 Years	30.20%	R
Other Low Income – 65+ Years	NA	R
Other Low Income – Total	45.09%	R

NA – Insufficient membership to report a rate (<30 members in denominator).

AGNJ Quality Improvement Projects

AGNJ QIP 1: Identification and Management of Adolescents Overweight and Obesity

QIP 1: June 2016 Project Year 2 Update (2) Review

Amerigroup New Jersey, Inc. - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF ADOLESCENTS OVERWEIGHT AND OBESITY				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	65
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: September 2016 Sustainability Year Update (1) Review

Amerigroup New Jersey, Inc. - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF ADOLESCENTS OVERWEIGHT AND OBESITY				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	80
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: June 2017 Sustainability Year Update (2) Review

Amerigroup New Jersey, Inc. - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF ADOLESCENTS OVERWEIGHT AND OBESITY				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	70
Review Element 10 - Sustainability of Documented Improvement	M	100	20%	20
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	20
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*90*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

AGNJ QIP 2: Reduction of Preterm Births – Increasing Progesterone Utilization Rates

QIP 2: June 2016 Project Year 1 Update (2) Review

Amerigroup New Jersey, Inc.- SUMMARY SCORING				
REDUCTION OF PRETERM BIRTHS – INCREASING PROGESTERONE UTILIZATION RATES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	62.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2016 Project Year 2 Update (1) Review

Amerigroup New Jersey, Inc.- SUMMARY SCORING				
REDUCTION OF PRETERM BIRTHS – INCREASING PROGESTERONE UTILIZATION RATES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	NM	0	15%	0
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	45
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: June 2017 Project Year 2 Update (2) Review

Amerigroup New Jersey, Inc.- SUMMARY SCORING				
REDUCTION OF PRETERM BIRTHS – INCREASING PROGESTERONE UTILIZATION RATES*				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	PM	50	5%	2.5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	NM	0	10%	0
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	35**
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

* The current submission reflects a reworking of the original project. This reworking includes establishing a new baseline year of 2016, Year 1 2017, Year 2 2018 and Sustainability Year 2019. The AIM of the project and population of focus has changed.

** 35 of possible 60 points; 85% of points for phase of project where 8/9 are N/A is 51; 60% is 36; Score is at level 3 of compliance.

AGNJ QIP 2: Reduction of Preterm Births by 5%

QIP 2: October 2017 Project Year 1 Update (1) Re-Review

Amerigroup New Jersey, Inc.- SUMMARY SCORING				
REDUCTION OF PRETERM BIRTHS BY 5%				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	60
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

AGNJ QIP 3: Prevention of Falls in the Managed Long Term Services and Support (MLTSS) Population

QIP 3: June 2016 Project Baseline Update Review

AMERIGROUP NEW JERSEY - SUMMARY SCORING				
PREVENTION OF FALLS IN THE MANAGED LONG TERM SERVICES AND SUPPORT (MLTSS) POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	NM	0	15%	0
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	30
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT - Current available points 60			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2016 Project Year 1 Update (1) Review

AMERIGROUP NEW JERSEY - SUMMARY SCORING				
PREVENTION OF FALLS IN THE MANAGED LONG TERM SERVICES AND SUPPORT (MLTSS) POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: June 2017 Project Year 1 Update (2) Review

AMERIGROUP NEW JERSEY - SUMMARY SCORING				
PREVENTION OF FALLS IN THE MANAGED LONG TERM SERVICES AND SUPPORT (MLTSS) POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	42.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2017 Project Year 2 Update (1) Review

AMERIGROUP NEW JERSEY - SUMMARY SCORING				
PREVENTION OF FALLS IN THE MANAGED LONG TERM SERVICES AND SUPPORT (MLTSS) POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	45
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

AGNJ QIP 4: Increasing the Utilization of Developmental Screening Tools and Awareness of Early Intervention Services for Members < 3 Years Old

QIP 4: September 2017 Proposal Review

AMERIGROUP NEW JERSEY, INC. - SUMMARY SCORING				
INCREASING THE UTILIZATION OF DEVELOPMENTAL SCREENING TOOLS AND AWARENESS OF EARLY INTERVENTION SERVICES FOR MEMBERS < 3 YEARS OLD				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	Partial	50	5%	2.5
Review Element 2 - Study Question (AIM Statement)	Met	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	Partial	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	Met	100	10%	10
Review Element 6 - Data Collection Procedures	Partial	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	Met	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	65-80	1	Requirements MET - Comments, Suggestions
	50-64	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

AGNJ Care Management Audits

AGNJ Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2015 (n=100)	2016 (n=100)	% Point Change	2015 (n=50)	2016 (n=36)	% Point Change	2015 (n=100)	2016 (n=100)	% Point Change
Identification	85%	92%	+7	100%	100%	0	100%	100%	0
Outreach	86%	87%	+1	100%	100%	0	99%	100%	+1
Preventive Services	88%	79%	-9	100%	100%	0	97%	97%	0
Continuity of Care	97%	99%	+2	94%	100%	+6	95%	100%	+5
Coordination of Services	100%	100%	0	99%	100%	+1	100%	99%	-1

AGNJ MLTSS HCBS Care Management Audits: July 2014–June 2017

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
#8. Initial Plan of Care established within 30 days of enrollment into MLTSS/HCBS.[1]	Group A&B	20	16	80.0%							
	Group C	34	23	67.6%	57	46	80.7%	43	38	88.4%	7.7
	Group D	46	16	34.8%	45	26	57.8%	57	46	80.7%	22.9
	Group E										
	Total	100	55	55.0%	102	72	70.6%	100	84	84.0%	13.4
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group A&B										
	Group C				4	4	100.0%	4	3	75.0%	-25.0
	Group D				1	1	100.0%	3	2	66.7%	-33.3
	Group E							13	11	84.6%	
	Total				5	5	100.0%	20	16	80.0%	-20.0
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group A&B										
	Group C				5	4	80.0%	2	2	100.0%	20.0
	Group D				6	6	100.0%	2	1	50.0%	-50.0
	Group E							6	0	0.0%	
	Total				11	10	90.9%	10	3	30.0%	-60.9
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	Group A&B	20	20	100.0%							
	Group C	34	33	97.1%	57	57	100.0%	38	37	97.4%	-2.6
	Group D	45	42	93.3%	41	40	97.6%	44	40	90.9%	-6.7
	Group E							18	16	88.9%	
	Total	99	95	96.0%	98	97	99.0%	100	93	93.0%	-6.0
#11. Plans of Care developed using "person-centered principles" [5]	Group A&B	20	20	100.0%							
	Group C	34	34	100.0%	57	35	61.4%	38	22	57.9%	-3.5
	Group D	45	42	93.3%	45	18	40.0%	44	27	61.4%	21.4
	Group E							18	18	100.0%	
	Total	99	96	97.0%	102	53	52.0%	100	67	67.0%	15.0
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group A&B	19	17	89.5%							
	Group C	20	20	100.0%	29	25	86.2%	21	8	38.1%	-48.1
	Group D	40	38	95.0%	39	32	82.1%	42	22	52.4%	-29.7
	Group E							15	4	26.7%	
	Total	79	75	94.9%	68	57	83.8%	78	34	43.6%	-40.2
#16. Member training on identifying/reporting critical incidents	Group A&B										
	Group C				57	57	100.0%	38	33	86.8%	-13.2
	Group D				45	44	97.8%	44	37	84.1%	-13.7

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
	Group E							18	18	100.0%	
	Total				102	101	99.0%	100	88	88.0%	-11.0

[1] From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.

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

[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.

[6]Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017.

In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing

Group A & B – Current Members converted to MLTSS on 7/1/2014. These members were only included in the initial review period.

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

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2016 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year	Subject to Review[1]	Subject to Review and Met[2]	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Access	8	6	2	2	8	0	0	100%	0	1	0
Quality Assessment and Performance Improvement	10	7	3	3	10	0	0	100%	0	2	0
Quality Management	13	9	4	1	10	3	0	77%	2	1	1
Efforts to Reduce Healthcare Disparities	4	0	4	1	1	3	0	25%	3	0	0
Committee Structure	9	7	2	2	9	0	0	100%	0	1	0
Programs for the Elderly and Disabled	44	43	2	0	42	2	0	95%	0	0	2
Provider Training and Performance	11	9	3	2	10	1	0	91%	1	0	0
Satisfaction	4	3	0	0	3	0	1	100%	0	0	0
Enrollee Rights and Responsibilities	8	7	3	3	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	33	13	9	33	4	0	89%	2	0	2
Credentialing and Recredentialing	10	9	2	2	10	0	0	100%	0	0	0
Utilization Management	22	19	4	3	21	1	0	95%	0	2	1
Administration and Operations	13	12	2	2	13	0	0	100%	0	0	0
Management Information Systems	18	15	5	4	17	1	0	94%	1	1	0
TOTAL	**211**	**179**	**49**	**34**	**195**	**15**	**1**	**93%**	**9**	**8**	**6**

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

HNJH 2017 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	8	8	8	8	0	0	100%	0	0	0
Quality Assessment and Performance Improvement	10	10	10	9	1	0	90%	0	0	1
Quality Management	17	10	17	16	1	0	94%	1	2	0
Efforts to Reduce Healthcare Disparities	5	1	5	3	2	0	60%	2	1	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	42	44	38	5	1	88%	1	1	4
Provider Training and Performance	11	10	11	11	0	0	100%	0	1	0
Satisfaction	4	3	4	3	1	0	75%	0	0	1
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	33	37	34	3	0	92%	1	3	2
Credentialing and Recredentialing	10	10	10	10	0	0	100%	0	0	0
Utilization Management	22	21	22	21	1	0	95%	0	1	1
Administration and Operations	13	13	13	11	2	0	85%	0	0	2
Management Information Systems	18	17	18	15	3	0	83%	0	1	3
TOTAL	**216**	**195**	**216**	**196**	**19**	**1**	**91%**	**5**	**10**	**14**

[1] A total of 49 elements were reviewed in the previous review period; of these 49, 34 were *Met*. All other elements (161) that are *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

HNJH Performance Measures

HNJH HEDIS 2016 Performance Measures

HNJH HEDIS 2016 Performance Measure	Rate	Status
Childhood Immunization (CIS)[1]		
Combination 2	54.99%	R
Combination 3	46.47%	R
Lead Screening in Children (LSC)	71.34%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)[1]	57.60%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	77.70%	R
Adolescent Well-Care Visits (AWC)	59.57%	R
Breast Cancer Screening (BCS)	55.68%	R
Cervical Cancer Screening (CCS)	52.07%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	80.47%	R
HbA1c Poor Control (>9.0%)[1,2]	49.45%	R
HbA1c Control (<8.0%)[1]	42.70%	R
HbA1c Control (<7.0%) for a Selected Population[1]	32.54%	R
Eye Exam	50.00%	R
Medical Attention for Nephropathy	91.42%	R
Blood Pressure Controlled <140/90 mm Hg[1]	25.36%	R
Controlling High Blood Pressure (CBP)[1]	17.63%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	79.08%	R
Postpartum Care	53.53%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)[1]	58.77%	R
Immunizations For Adolescents (IMA)		
Meningococcal	85.30%	R
Tdap/Td	93.93%	R
Combination 1	84.03%	R
Appropriate testing for children with pharyngitis (CWP)	64.19%	R
Chlamydia Screening (CHL)		
16-20	44.96%	R
21-24	55.06%	R

HNJH HEDIS 2016 Performance Measure	Rate	Status
Total	49.54%	R
BMI assessment for children/adolescents (WCC) [1]		
3-11	45.49%	R
12-17	40.40%	R
Total	43.54%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	27.00%	R
Continuation and Maintenance Phase	30.97%	R
Follow-up after hospitalization for mental illness (FUH) [3]		
30 Day Followup	16.39%	R
7 Day Followup	5.74%	R
Adult BMI Assessment (ABA) [1]	42.82%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	86.47%	R
Digoxin	53.94%	R
Diuretics	85.41%	R
Total	85.87%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	97.92%	R
25 months - 6 years	93.52%	R
7-11 years	96.26%	R
12-19 years	93.83%	R
Human Papillomavirus Vaccine for Female Adolescents (HPV) [1]	22.87%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	47.87%	R
5-11 Years - 75% Compliance	24.12%	R
12-18 Years - 50% Compliance	47.76%	R
12-18 Years - 75% Compliance	25.00%	R
19-50 Years - 50% Compliance	61.39%	R
19-50 Years - 75% Compliance	37.55%	R
51-64 Years - 50% Compliance	73.13%	R
51-64 Years - 75% Compliance	51.37%	R
Total - 50% Compliance	55.33%	R
Total - 75% Compliance	32.08%	R

HNJH HEDIS 2016 Performance Measure	Rate	Status
Annual Dental Visit (ADV)		
Total - 2-3 Years	48.69%	R
Total - 4-6 Years	70.48%	R
Total - 7-10 Years	73.95%	R
Total - 11-14 Years	69.02%	R
Total - 15-18 Years	59.69%	R
Total - 19-20 Years	46.85%	R
Total - Total	65.47%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
< 1 Year - Total Medicaid	1,124.45	R
1-9 Years - Total Medicaid	434.38	R
10-19 Years - Total Medicaid	308.50	R
20-44 Years - Total Medicaid	391.35	R
45-64 Years - Total Medicaid	652.44	R
65-74 Years - Total Medicaid	717.79	R
75-84 Years - Total Medicaid	679.49	R
85+ Years - Total Medicaid	668.16	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	448.16	R
<1 Year - Dual-Eligibles	1,103.20	R
1-9 Years - Dual-Eligibles	153.85	R
10-19 Years - Dual-Eligibles	NA	R
20-44 Years - Dual-Eligibles	236.02	R
45-64 Years - Dual-Eligibles	550.00	R
65-74 Years - Dual-Eligibles	377.05	R
75-84 Years - Dual-Eligibles	303.03	R
85+ Years - Dual-Eligibles	0.00	R
Unknown - Dual-Eligibles	NA	R
Total - Dual-Eligibles	533.81	R
< 1 Year - Disabled	1,376.28	R
1-9 Years - Disabled	592.06	R
10-19 Years - Disabled	353.75	R
20-44 Years - Disabled	497.76	R
45-64 Years - Disabled	927.84	R

HNJH HEDIS 2016 Performance Measure	Rate	Status
65-74 Years - Disabled	702.88	R
75-84 Years - Disabled	665.99	R
85+ Years - Disabled	649.80	R
Unknown - Disabled	NA	R
Total - Disabled	670.93	R
<1 Year - Other Low Income	1,100.20	R
1-9 Years - Other Low Income	423.62	R
10-19 Years - Other Low Income	301.52	R
20-44 Years - Other Low Income	376.67	R
45-64 Years - Other Low Income	575.93	R
65-74 Years - Other Low Income	835.48	R
75-84 Years - Other Low Income	928.57	R
85+ Years - Other Low Income	0.00	R
Unknown - Other Low Income	NA	R
Total - Other Low Income	422.15	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
< 1 Year - Total Medicaid	108.73	R
1-9 Years - Total Medicaid	55.87	R
10-19 Years - Total Medicaid	43.59	R
20-44 Years - Total Medicaid	97.37	R
45-64 Years - Total Medicaid	74.04	R
65-74 Years - Total Medicaid	34.87	R
75-84 Years - Total Medicaid	29.56	R
85+ Years - Total Medicaid	36.25	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	68.55	R
Dual Eligibles - <1 Years	113.88	R
Dual Eligibles - 1-9 Years	0.00	R
Dual Eligibles - 10-19 Years	NA	R
Dual Eligibles - 20-44 Years	105.59	R
Dual Eligibles - 45-64 Years	60.00	R
Dual Eligibles - 65-74 Years	16.39	R
Dual Eligibles - 75-84 Years	90.91	R
Dual Eligibles - 85+ Years	0.00	R

HNJH HEDIS 2016 Performance Measure	Rate	Status
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	87.26	R
Disabled - <1 Years	149.41	R
Disabled - 1-9 Years	81.74	R
Disabled - 10-19 Years	68.94	R
Disabled - 20-44 Years	149.69	R
Disabled - 45-64 Years	136.98	R
Disabled - 65-74 Years	34.50	R
Disabled - 75-84 Years	29.54	R
Disabled - 85+ Years	36.99	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	113.77	R
Other Low Income - <1 Years	107.44	R
Other Low Income - 1-9 Years	54.92	R
Other Low Income - 10-19 Years	41.95	R
Other Low Income - 20-44 Years	93.01	R
Other Low Income - 45-64 Years	59.24	R
Other Low Income - 65-74 Years	64.52	R
Other Low Income - 75-84 Years	107.14	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	64.45	R

[1] HNJH did not complete the medical record review for hybrid measures for HEDIS 2016, resulting in potential bias for some hybrid measures. This measure demonstrated potential bias greater than or equal to 10%.

[2] Higher rates for HbA1c Poor Control indicate poorer performance.

[3] This measure is only applicable for MLTSS and DDD members.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

HNJH NJ-Specific 2016 Performance Measures

HNJH NJ-Specific 2016 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]		
Total Medicaid - 20-44 years	82.11%	R
Total Medicaid - 45-64 years	88.98%	R
Total Medicaid - 65+ years	87.68%	R
Total Medicaid - Total	84.87%	R
Dual Eligibles - 20-44 years	82.35%	R
Dual Eligibles - 45-64 years	94.44%	R
Dual Eligibles - 65+ years	75.00%	R
Dual Eligibles - Total	87.18%	R
Disabled - 20-44 years	85.03%	R
Disabled - 45-64 years	93.93%	R
Disabled - 65+ years	87.67%	R
Disabled - Total	90.26%	R
Other Low Income - 20-44 years	81.79%	R
Other Low Income - 45-64 years	87.33%	R
Other Low Income - 65+ years	89.13%	R
Other Low Income - Total	83.74%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)[1]		
Total Medicaid – 12-24 months	97.92%	R
Total Medicaid – 25 months – 6 years	93.52%	R
Total Medicaid – 7-11 years	96.26%	R
Total Medicaid – 12-19 years	93.83%	R
Total Medicaid – 12 months-19 years	94.64%	R
Dual Eligibles – 12-24 months	NA	R
Dual Eligibles – 25 months – 6 years	NA	R
Dual Eligibles – 7-11 years	0.00%	R
Dual Eligibles – 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	0.00%	R
Disabled – 12-24 months	95.88%	R
Disabled – 25 months – 6 years	94.52%	R
Disabled – 7-11 years	97.21%	R
Disabled – 12-19 years	92.42%	R
Total Disabled – 12 months-19 years	94.32%	R
Other Low Income – 12-24 months	97.95%	R
Other Low Income – 25 months – 6 years	93.49%	R

HNJH NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income – 7-11 years	96.22%	R
Other Low Income – 12-19 years	93.94%	R
Total Other Low Income – 12 months-19 years	94.66%	R
Preventive Dental Visit[2]		
Total - 2-3 Years	48.36%	R
Total - 4-6 Years	67.89%	R
Total - 7-10 Years	70.20%	R
Total - 11-14 Years	63.69%	R
Total - 15-18 Years	52.63%	R
Total - 19-21 Years	37.90%	R
Total - 22-34 Years	35.47%	R
Total - 35-64 Years	36.71%	R
Total - 65+ Years	24.90%	R
Total - Total	48.46%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	0.00%	R
Dual Eligibles - 11-14 Years	100.00%	R
Dual Eligibles - 15-18 Years	0.00%	R
Dual Eligibles - 19-21 Years	41.79%	R
Dual Eligibles - 22-34 Years	35.38%	R
Dual Eligibles - 35-64 Years	37.96%	R
Dual Eligibles - 65+ Years	25.16%	R
Dual Eligibles - Total	30.43%	R
Disabled - 2-3 Years	40.19%	R
Disabled - 4-6 Years	60.01%	R
Disabled - 7-10 Years	61.48%	R
Disabled - 11-14 Years	53.80%	R
Disabled - 15-18 Years	44.72%	R
Disabled - 19-21 Years	31.97%	R
Disabled - 22-34 Years	30.94%	R
Disabled - 35-64 Years	31.06%	R
Disabled - 65+ Years	22.47%	R
Disabled - Total	36.29%	R
Other Low Income - 2-3 Years	48.52%	R

HNJH NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income - 4-6 Years	68.18%	R
Other Low Income - 7-10 Years	70.62%	R
Other Low Income - 11-14 Years	64.30%	R
Other Low Income - 15-18 Years	53.16%	R
Other Low Income - 19-21 Years	38.78%	R
Other Low Income - 22-34 Years	36.02%	R
Other Low Income - 35-64 Years	37.70%	R
Other Low Income - 65+ Years	25.00%	R
Other Low Income - Total	52.27%	R

[1] HNJH does not include Dual Eligible membership in this measure, as Dual Eligible members are not included in their HEDIS population. After the HEDIS measures are produced, HNJH adds the enrollment identifiers to the data to produce the subpopulation results. Due to the delay from when the enrollment data is frozen for HEDIS reporting, and when the New Jersey Performance Measures are run, a small number of members have retroactively changed enrollment to Dual Eligible. These members are reported as Dual Eligible in the performance measures.

[2] HNJH does include Dual Eligible members in the Preventive Dental Measure. These are members in the TPL file with Medicare coverage and/or commercial coverage.

NA – No members in denominator

HNJH HEDIS 2017 Performance Measures

HNJH HEDIS 2017 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	70.32%	R
Combination 3	60.34%	R
Combination 9	32.36%	R
Lead Screening in Children (LSC)	73.98%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	62.78%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	78.38%	R
Adolescent Well-Care Visits (AWC)	59.05%	R
Breast Cancer Screening (BCS)	59.23%	R
Cervical Cancer Screening (CCS)	58.29%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	85.77%	R
HbA1c Poor Control (>9.0%)[2]	37.04%	R
HbA1c Control (<8.0%)	53.65%	R
HbA1c Control (<7.0%) for a Selected Population	39.90%	R
Eye Exam	62.04%	R
Medical Attention for Nephropathy	88.50%	R
Blood Pressure Controlled <140/90 mm Hg[1]	52.74%	R
Controlling High Blood Pressure (CBP)[1]	39.66%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	79.56%	R
Postpartum Care	56.69%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	54.61%	R
Immunizations For Adolescents (IMA)		
Meningococcal	89.05%	R
Tdap/Td	89.54%	R
HPV [4]	20.44%	R
Combination 1	83.45%	R
Combination 2	16.79%	R
Appropriate testing for children with pharyngitis (CWP)	58.07%	R
Chlamydia Screening (CHL)		
16-20	51.54%	R

HNJH HEDIS 2017 Performance Measure	Rate	Status
21-24	62.04%	R
Total	56.22%	R
BMI assessment for children/adolescents (WCC)		
BMI percentile - 3-11 Years	63.80%	R
BMI percentile - 12-17 Years	62.12%	R
BMI percentile - Total	63.26%	R
Counseling for Nutrition - 3-11 Years	60.93%	R
Counseling for Nutrition - 12-17 Years	63.64%	R
Counseling for Nutrition - Total	61.80%	R
Counseling for Physical Activity - 3-11 Years	54.48%	R
Counseling for Physical Activity - 12-17 Years	59.85%	R
Counseling for Physical Activity - Total	56.20%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	27.35%	R
Continuation and Maintenance Phase	31.91%	R
Follow-up after hospitalization for mental illness (FUH)[3]		
30 Day Followup	15.79%	R
7 Day Followup	5.26%	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[3]		
30 Day Followup	70.09%	R
7 Day Followup	54.17%	R
Adult BMI Assessment (ABA)[1]	75.18%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	88.88%	R
Digoxin	50.20%	R
Diuretics	87.82%	R
Total	88.26%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	97.89%	R
25 months - 6 years	92.49%	R
7-11 years	95.88%	R
12-19 years	93.57%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	53.02%	R

HNJH HEDIS 2017 Performance Measure	Rate	Status
12-18 Years - 50% Compliance	50.69%	R
19-50 Years - 50% Compliance	64.19%	R
51-64 Years - 50% Compliance	75.82%	R
Total - 50% Compliance	59.89%	R
5-11 Years - 75% Compliance	27.37%	R
12-18 Years - 75% Compliance	26.09%	R
19-50 Years - 75% Compliance	40.20%	R
51-64 Years - 75% Compliance	53.64%	R
Total - 75% Compliance	35.59%	R
Annual Dental Visit (ADV)		
Total - 2-3 Years	49.61%	R
Total - 4-6 Years	70.58%	R
Total - 7-10 Years	75.01%	R
Total - 11-14 Years	71.11%	R
Total - 15-18 Years	62.81%	R
Total - 19-20 Years	48.24%	R
Total - Total	66.86%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
Total Medicaid - < 1 Year	585.70	R
Total Medicaid - 1-9 Years	468.90	R
Total Medicaid - 10-19 Years	319.41	R
Total Medicaid - 20-44 Years	380.50	R
Total Medicaid - 45-64 Years	672.14	R
Total Medicaid - 65-74 Years	829.18	R
Total Medicaid - 75-84 Years	731.97	R
Total Medicaid - 85+ Years	741.57	R
Total Medicaid - Unknown	NA	R
Total Medicaid - Total	445.98	R
Dual-Eligibles - < 1 Year	NA	R
Dual-Eligibles - 1-9 Years	4,000.00	R
Dual-Eligibles - 10-19 Years	1,000.00	R
Dual-Eligibles - 20-44 Years	335.44	R
Dual-Eligibles - 45-64 Years	807.02	R
Dual-Eligibles - 65-74 Years	559.57	R

HNJH HEDIS 2017 Performance Measure	Rate	Status
Dual-Eligibles - 75-84 Years	1,145.30	R
Dual-Eligibles - 85+ Years	1,892.05	R
Dual-Eligibles - Unknown	NA	R
Dual-Eligibles - Total	909.36	R
Disabled - < 1 Year	1,262.04	R
Disabled - 1-9 Years	619.30	R
Disabled - 10-19 Years	373.39	R
Disabled - 20-44 Years	515.75	R
Disabled - 45-64 Years	983.21	R
Disabled - 65-74 Years	781.71	R
Disabled - 75-84 Years	703.05	R
Disabled - 85+ Years	670.23	R
Disabled - Unknown	NA	R
Disabled - Total	710.68	R
Other Low Income - < 1 Year	1,262.59	R
Other Low Income - 1-9 Years	464.81	R
Other Low Income - 10-19 Years	306.00	R
Other Low Income - 20-44 Years	366.84	R
Other Low Income - 45-64 Years	582.55	R
Other Low Income - 65-74 Years	656.63	R
Other Low Income - 75-84 Years	NA	R
Other Low Income - 85+ Years	191.36	R
Other Low Income - Unknown	NA	R
Other Low Income - Total	424.00	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	51.68	R
Total - 1-9 Years	62.40	R
Total - 10-19 Years	44.29	R
Total - 20-44 Years	101.94	R
Total - 45-64 Years	88.37	R
Total - 65-74 Years	49.60	R
Total - 75-84 Years	41.54	R
Total - 85+ Years	58.65	R
Total - Unknown Years	NA	R

HNJH HEDIS 2017 Performance Measure	Rate	Status
Total - Total Years	72.79	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	400.00	R
Dual Eligibles - 10-19 Years	125.00	R
Dual Eligibles - 20-44 Years	69.62	R
Dual Eligibles - 45-64 Years	161.40	R
Dual Eligibles - 65-74 Years	83.03	R
Dual Eligibles - 75-84 Years	94.02	R
Dual Eligibles - 85+ Years	221.59	R
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	129.63	R
Disabled - <1 Years	147.31	R
Disabled - 1-9 Years	96.15	R
Disabled - 10-19 Years	70.27	R
Disabled - 20-44 Years	162.51	R
Disabled - 45-64 Years	161.19	R
Disabled - 65-74 Years	45.86	R
Disabled - 75-84 Years	39.76	R
Disabled - 85+ Years	50.71	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	129.11	R
Other Low Income - <1 Years	110.97	R
Other Low Income - 1-9 Years	61.47	R
Other Low Income - 10-19 Years	41.45	R
Other Low Income - 20-44 Years	96.58	R
Other Low Income - 45-64 Years	69.45	R
Other Low Income - 65-74 Years	43.98	R
Other Low Income - 75-84 Years	NA	R
Other Low Income - 85+ Years	43.21	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	68.12	R

[1] HNJH did not complete the medical record review for all hybrid measures for HEDIS 2017, resulting in potential bias for three hybrid measures: ABA, CBP, and CDC-Blood Pressure Controlled <140/90 mm Hg for a Selected Population. These measures demonstrated potential bias greater than or equal to 10%, therefore were excluded from the state weighted and unweighted averages.

[2] HbA1c Poor Control is an inverted measure. Higher rates for HbA1c Poor Control indicate poorer performance.

[3] Follow-up After Hospitalization and Follow-Up After Emergency Department Visit for Mental Illness are only applicable to members who receive a behavioral health benefit. This is limited to the MLTSS and DDD members.
[4] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.
NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others).

HNJH NJ-Specific 2017 Performance Measures

HNJH NJ-Specific 2017 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]		
Total Medicaid - 20-44 years	80.70%	R
Total Medicaid - 45-64 years	88.49%	R
Total Medicaid - 65+ years	89.81%	R
Total Medicaid - Total	83.89%	R
Dual Eligibles - 20-44 years	NA	R
Dual Eligibles - 45-64 years	NA	R
Dual Eligibles - 65+ years	NA	R
Dual Eligibles - Total	85.00%	R
Disabled - 20-44 years	85.28%	R
Disabled - 45-64 years	93.98%	R
Disabled - 65+ years	89.92%	R
Disabled - Total	90.63%	R
Other Low Income - 20-44 years	80.26%	R
Other Low Income - 45-64 years	86.96%	R
Other Low Income - 65+ years	81.36%	R
Other Low Income - Total	82.67%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid – 12-24 months	97.89%	R
Total Medicaid – 25 months – 6 years	92.49%	R
Total Medicaid – 7-11 years	95.88%	R
Total Medicaid – 12-19 years	93.57%	R
Total Medicaid – 12 months-19 years	94.12%	R
Dual Eligibles – 12-24 months	NA	R
Dual Eligibles – 25 months – 6 years	NA	R
Dual Eligibles – 7-11 years	NA	R
Dual Eligibles – 12-19 years	NA	R
Total Dual Eligibles – 12 months-19 years	NA	R
Disabled – 12-24 months	98.67%	R
Disabled – 25 months – 6 years	93.57%	R
Disabled – 7-11 years	96.15%	R
Disabled – 12-19 years	92.06%	R
Total Disabled – 12 months-19 years	93.70%	R
Other Low Income – 12-24 months	97.88%	R
Other Low Income – 25 months – 6 years	92.47%	R

HNJH NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income – 7-11 years	95.87%	R
Other Low Income – 12-19 years	93.67%	R
Total Other Low Income – 12 months-19 years	94.14%	R
Preventive Dental Visit		
Total - 2-3 Years	49.32%	R
Total - 4-6 Years	68.14%	R
Total - 7-10 Years	71.65%	R
Total - 11-14 Years	66.21%	R
Total - 15-18 Years	55.68%	R
Total - 19-21 Years	40.25%	R
Total - 22-34 Years	36.95%	R
Total - 35-64 Years	37.53%	R
Total - 65+ Years	27.10%	R
Total - Total	49.51%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	41.67%	R
Dual Eligibles - 22-34 Years	38.18%	R
Dual Eligibles - 35-64 Years	39.45%	R
Dual Eligibles - 65+ Years	27.65%	R
Dual Eligibles - Total	32.46%	R
Disabled - 2-3 Years	43.04%	R
Disabled - 4-6 Years	57.97%	R
Disabled - 7-10 Years	63.02%	R
Disabled - 11-14 Years	55.96%	R
Disabled - 15-18 Years	48.79%	R
Disabled - 19-21 Years	33.68%	R
Disabled - 22-34 Years	32.76%	R
Disabled - 35-64 Years	31.58%	R
Disabled - 65+ Years	21.99%	R
Disabled - Total	37.23%	R
Other Low Income - 2-3 Years	49.45%	R

HNJH NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income - 4-6 Years	68.49%	R
Other Low Income - 7-10 Years	72.06%	R
Other Low Income - 11-14 Years	66.80%	R
Other Low Income - 15-18 Years	56.12%	R
Other Low Income - 19-21 Years	41.01%	R
Other Low Income - 22-34 Years	37.34%	R
Other Low Income - 35-64 Years	38.37%	R
Other Low Income - 65+ Years	NA	R
Other Low Income - Total	53.05%	R

NA – Insufficient membership to report a rate (<30 members in denominator).

HNJH Quality Improvement Projects

HNJH QIP 1: Identification and Management of Obesity in the Adolescent Population

QIP 1: June 2016 Project Year 2 Update (2) Review

Horizon NJ Health - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF OBESITY IN THE ADOLESCENT POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: September 2016 Project Sustainability Year Update (1) Review

Horizon NJ Health - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF OBESITY IN THE ADOLESCENT POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: June 2017 Project Sustainability Year Update (2) Review

Horizon NJ Health - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF OBESITY IN THE ADOLESCENT POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	10
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*67.5*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

HNJH QIP 2: Improving Early Identification of Pregnancy and Birth Outcomes

QIP 2: June 2016 Project Year 1 Update (2) Review

Horizon NJ Health - SUMMARY SCORING				
IMPROVING EARLY IDENTIFICATION OF PREGNANCY AND BIRTH OUTCOMES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	47.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2016 Project Year 2 Update (1) Review

Horizon NJ Health - SUMMARY SCORING				
IMPROVING EARLY IDENTIFICATION OF PREGNANCY AND BIRTH OUTCOMES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	45
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: June 2017 Project Year 2 Update (2) Review

Horizon NJ Health - SUMMARY SCORING				
IMPROVING EARLY IDENTIFICATION OF PREGNANCY AND BIRTH OUTCOMES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	62.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2017 Project Sustainability Year 3 Update (1) Review

Horizon NJ Health - SUMMARY SCORING				
IMPROVING EARLY IDENTIFICATION OF PREGNANCY AND BIRTH OUTCOMES				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	72.5
Review Element 10 - Sustainability of Documented Improvement	M	100	20%	20
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	92.5
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

HNJH QIP 3: Prevention of Recurrent Falls among Managed Long Term Services and Supports (MLTSS) Members

QIP 3: June 2016 Project Baseline Update Review

HORIZON NJ HEALTH - SUMMARY SCORING				
PREVENTION OF RECURRENT FALLS AMONG MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) MEMBERS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	47.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT – Current available points 60			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2016 Project Year 1 Update (1) Review

HORIZON NJ HEALTH - SUMMARY SCORING				
PREVENTION OF RECURRENT FALLS AMONG MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) MEMBERS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: June 2017 Project Year 1 Update (2) Review

HORIZON NJ HEALTH - SUMMARY SCORING				
PREVENTION OF RECURRENT FALLS AMONG MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) MEMBERS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	80
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2017 Project Year 2 Update (1) Review

HORIZON NJ HEALTH - SUMMARY SCORING				
PREVENTION OF RECURRENT FALLS AMONG MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) MEMBERS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	70
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan

HNJH QIP 4: Developmental Screening and Early Intervention in Young Children

QIP 4: September 2017 Proposal Review

HORIZON NEW JERSEY HEALTH - SUMMARY SCORING				
DEVELOPMENTAL SCREENING AND EARLY INTERVENTION IN YOUNG CHILDREN				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	MET	100	5%	5
Review Element 2 - Study Question (AIM Statement)	MET	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	MET	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	MET	100	10%	10
Review Element 6 - Data Collection Procedures	PARTIAL MET	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	MET	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	65-80	1	Requirements MET - Comments, Suggestions
	50-64	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

HNJH Care Management Audits

HNJH Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2015 (n=101)	2016 (n=102)	% Point Change	2015 (n=100)	2016 (n=100)	% Point Change	2015 (n=100)	2016 (n=100)	% Point Change
Identification	85%	89%	+4	94%	100%	+6	100%	100%	0
Outreach	61%	70%	+9	68%	89%	+21	83%	86%	+3
Preventive Services	96%	100%	+4	80%	93%	+13	93%	94%	+1
Continuity of Care	99%	97%	-2	74%	95%	+21	81%	99%	+18
Coordination of Services	100%	100%	0	91%	98%	+7	94%	100%	+6

HNJH MLTSS HCBS Care Management Audits: July 2014–June 2017

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
#8. Initial Plan of Care established within 30 days of enrollment into MLTSS/HCBS.[1]	Group A&B	34	14	41.2%							
	Group C	22	14	63.6%	46	38	82.6%	39	34	87.2%	4.6
	Group D	44	27	61.4%	52	46	88.5%	61	51	83.6%	-4.9
	Group E										
	Total	100	55	55.0%	98	84	85.7%	100	85	85.0%	-0.7
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group A&B										
	Group C				4	4	100.0%	1	1	100.0%	0.0
	Group D				4	3	75.0%	9	7	77.8%	2.8
	Group E							17	16	94.1%	
	Total				8	7	87.5%	27	24	88.9%	1.4
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group A&B										
	Group C				10	6	60.0%	5	5	100.0%	40.0
	Group D				6	5	83.3%	8	5	62.5%	-20.8
	Group E							2	2	100.0%	
	Total				16	11	68.8%	15	12	80.0%	11.2
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	Group A&B	34	32	94.1%							
	Group C	21	13	61.9%	44	43	97.7%	31	29	93.5%	-4.2
	Group D	42	39	92.9%	52	49	94.2%	50	46	92.0%	-2.2
	Group E							18	16	88.9%	
	Total	97	84	86.6%	96	92	95.8%	99	91	91.9%	-3.9
#11. Plans of Care developed using "person-centered principles" [5]	Group A&B	34	19	55.9%							
	Group C	22	14	63.6%	46	36	78.3%	31	26	83.9%	5.6
	Group D	42	37	88.1%	52	36	69.2%	50	38	76.0%	6.8
	Group E							18	11	61.1%	
	Total	98	70	71.4%	98	72	73.5%	99	75	75.8%	2.3
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group A&B	25	20	80.0%							
	Group C	14	11	78.6%	22	19	86.4%	26	26	100.0%	13.6
	Group D	40	29	72.5%	47	44	93.6%	46	43	93.5%	-0.1
	Group E							10	10	100.0%	
	Total	79	60	75.9%	69	63	91.3%	82	79	96.3%	5.0
#16. Member training on identifying/reporting critical incidents	Group A&B										
	Group C				46	44	95.7%	31	29	93.5%	-2.2
	Group D				52	46	88.5%	50	46	92.0%	3.5

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
	Group E							18	16	88.9%	
	Total				98	90	91.8%	99	91	91.9%	0.1

[1] From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.

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

[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.

[6]Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017.

In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing

Group A & B – Current Members converted to MLTSS on 7/1/2014. These members were only included in the initial review period.

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

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2016 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year	Subject to Review[1]	Subject to Review and Met[2]	Total Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
									Prior	Resolved	New
Access	8	5	3	1	6	2	0	75%	2	0	0
Quality Assessment and Performance Improvement	10	9	0	0	9	0	1	100%	0	0	0
Quality Management	13	8	5	2	10	3	0	77%	2	2	1
Efforts to Reduce Healthcare Disparities	4	2	2	1	3	1	0	75%	1	0	0
Committee Structure	9	6	3	3	9	0	0	100%	0	2	0
Programs for the Elderly and Disabled	44	43	2	2	44	0	0	100%	0	0	0
Provider Training and Performance	11	9	2	2	11	0	0	100%	0	1	0
Satisfaction	4	3	0	0	3	0	1	100%	0	0	0
Enrollee Rights and Responsibilities	8	7	3	3	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	32	14	13	36	1	0	97%	0	3	1
Credentialing and Recredentialing	10	8	3	3	10	0	0	100%	0	1	0
Utilization Management	22	20	3	2	21	1	0	95%	1	0	0
Administration and Operations	13	11	3	3	13	0	0	100%	0	1	0
Management Information Systems	18	16	5	5	18	0	0	100%	0	1	0
TOTAL	**211**	**179**	**48**	**40**	**201**	**8**	**2**	**96%**	**6**	**11**	**2**

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

UHCCP 2017 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Met[3]	Not Met	N/A	% Met[4]	Deficiency Status		
								Prior	Resolved	New
Access	8	6	8	6	2	0	75%	2	0	0
Quality Assessment and Performance Improvement	10	9	10	10	0	0	100%	0	0	0
Quality Management	17	10	17	14	3	0	82%	2	1	1
Efforts to Reduce Healthcare Disparities	5	3	5	5	0	0	100%	0	1	0
Committee Structure	9	9	9	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	44	44	39	4	1	91%	0	0	4
Provider Training and Performance	11	11	11	10	1	0	91%	0	0	1
Satisfaction	4	3	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	8	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	36	37	37	0	0	100%	0	1	0
Credentialing and Recredentialing	10	10	10	9	1	0	90%	0	0	1
Utilization Management	22	21	22	18	4	0	82%	1	0	3
Administration and Operations	13	13	13	11	2	0	85%	0	0	2
Management Information Systems	18	18	18	18	0	0	100%	0	0	0
TOTAL	**216**	**201**	**216**	**198**	**17**	**1**	**92%**	**5**	**3**	**12**

[1] A total of 48 elements were reviewed in the previous review period; of these 48, 40 were *Met*. All other elements (161) that are *Met Prior Year* were deemed *Met* in the previous review period.

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

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

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

UHCCP Performance Measures

UHCCP HEDIS 2016 Performance Measures

UHCCP HEDIS 2016 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	65.69%	R
Combination 3	59.37%	R
Lead Screening in Children (LSC)	75.67%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	64.96%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	76.74%	R
Adolescent Well-Care Visits (AWC)	56.59%	R
Breast Cancer Screening (BCS)	55.84%	R
Cervical Cancer Screening (CCS)	62.63%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	85.12%	R
HbA1c Poor Control (>9.0%)[1]	44.51%	R
HbA1c Control (<8.0%)	45.62%	R
HbA1c Control (<7.0%) for a Selected Population	34.78%	R
Eye Exam	57.86%	R
Medical Attention for Nephropathy	90.68%	R
Blood Pressure Controlled <140/90 mm Hg	57.30%	R
Controlling High Blood Pressure (CBP)	49.88%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	81.27%	R
Postpartum Care	61.56%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	50.36%	R
Immunizations For Adolescents (IMA)		
Meningococcal	83.21%	R
Tdap/Td	88.81%	R
Combination 1	81.27%	R
Appropriate testing for children with pharyngitis (CWP)	76.64%	R
Chlamydia Screening (CHL)		
16-20	56.31%	R
21-24	61.37%	R

UHCCP HEDIS 2016 Performance Measure	Rate	Status
Total	58.57%	R
BMI assessment for children/adolescents (WCC)		
3-11	64.94%	R
12-17	58.57%	R
Total	62.77%	R
Follow-up care for children prescribed ADHD medication (ADD)		
Initial Phase	39.38%	R
Continuation and Maintenance Phase	42.96%	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	69.63%	R
7 Day Followup	57.04%	R
Adult BMI Assessment (ABA)	85.64%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	89.92%	R
Digoxin	43.07%	R
Diuretics	89.30%	R
Total	89.27%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	97.42%	R
25 months - 6 years	93.34%	R
7-11 years	95.08%	R
12-19 years	92.93%	R
Human Papillomavirus Vaccine for Female Adolescents (HPV)	20.19%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	46.70%	R
5-11 Years - 75% Compliance	23.39%	R
12-18 Years - 50% Compliance	46.99%	R
12-18 Years - 75% Compliance	23.86%	R
19-50 Years - 50% Compliance	55.89%	R
19-50 Years - 75% Compliance	31.26%	R
51-64 Years - 50% Compliance	72.60%	R
51-64 Years - 75% Compliance	51.23%	R
Total - 50% Compliance	51.84%	R
Total - 75% Compliance	28.43%	R

UHCCP HEDIS 2016 Performance Measure	Rate	Status
Annual Dental Visit (ADV)		
Total - 2-3 Years	44.30%	R
Total - 4-6 Years	69.45%	R
Total - 7-10 Years	73.09%	R
Total - 11-14 Years	67.81%	R
Total - 15-18 Years	57.49%	R
Total - 19-20 Years	42.90%	R
Total - Total	63.71%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
< 1 Year - Total Medicaid	816.42	R
1-9 Years - Total Medicaid	371.79	R
10-19 Years - Total Medicaid	261.65	R
20-44 Years - Total Medicaid	332.51	R
45-64 Years - Total Medicaid	560.25	R
65-74 Years - Total Medicaid	705.45	R
75-84 Years - Total Medicaid	543.85	R
85+ Years - Total Medicaid	209.86	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	379.99	R
< 1 Year - Dual-Eligibles	NA	R
1-9 Years - Dual-Eligibles	416.67	R
10-19 Years - Dual-Eligibles	521.74	R
20-44 Years - Dual-Eligibles	469.95	R
45-64 Years - Dual-Eligibles	679.16	R
65-74 Years - Dual-Eligibles	718.35	R
75-84 Years - Dual-Eligibles	496.97	R
85+ Years - Dual-Eligibles	130.23	R
Unknown - Dual-Eligibles	NA	R
Total - Dual-Eligibles	522.12	R
< 1 Year - Disabled	1,004.24	R
1-9 Years - Disabled	486.08	R
10-19 Years - Disabled	288.67	R
20-44 Years - Disabled	366.01	R
45-64 Years - Disabled	830.41	R

UHCCP HEDIS 2016 Performance Measure	Rate	Status
65-74 Years - Disabled	689.78	R
75-84 Years - Disabled	613.95	R
85+ Years - Disabled	517.24	R
Unknown - Disabled	NA	R
Total - Disabled	548.22	R
< 1 Year - Other Low Income	814.60	R
1-9 Years - Other Low Income	368.52	R
10-19 Years - Other Low Income	260.07	R
20-44 Years - Other Low Income	329.58	R
45-64 Years - Other Low Income	509.28	R
65-74 Years - Other Low Income	661.10	R
75-84 Years - Other Low Income	187.50	R
85+ Years - Other Low Income	219.30	R
Unknown - Other Low Income	NA	R
Total - Other Low Income	364.53	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	76.26	R
Total - 1-9 Years	42.52	R
Total - 10-19 Years	34.88	R
Total - 20-44 Years	70.62	R
Total - 45-64 Years	61.61	R
Total - 65-74 Years	44.68	R
Total - 75-84 Years	40.64	R
Total - 85+ Years	28.18	R
Total - Unknown Years	NA	R
Total - Total Years	52.56	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	0.00	R
Dual Eligibles - 10-19 Years	21.74	R
Dual Eligibles - 20-44 Years	101.57	R
Dual Eligibles - 45-64 Years	94.15	R
Dual Eligibles - 65-74 Years	55.60	R
Dual Eligibles - 75-84 Years	46.97	R
Dual Eligibles - 85+ Years	26.22	R

UHCCP HEDIS 2016 Performance Measure	Rate	Status
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	58.15	R
Disabled - <1 Years	137.20	R
Disabled - 1-9 Years	73.63	R
Disabled - 10-19 Years	57.10	R
Disabled - 20-44 Years	101.67	R
Disabled - 45-64 Years	116.95	R
Disabled - 65-74 Years	31.00	R
Disabled - 75-84 Years	31.27	R
Disabled - 85+ Years	32.13	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	88.66	R
Other Low Income - <1 Years	75.67	R
Other Low Income - 1-9 Years	41.63	R
Other Low Income - 10-19 Years	33.59	R
Other Low Income - 20-44 Years	68.23	R
Other Low Income - 45-64 Years	50.95	R
Other Low Income - 65-74 Years	26.25	R
Other Low Income - 75-84 Years	0.00	R
Other Low Income - 85+ Years	175.44	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	49.68	R

[1] HbA1c Poor Control is an inverted measure. Lower rates indicate better performance.

[2] This measure is only applicable for MLTSS and DDD members.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

UHCCP NJ-Specific 2016 Performance Measures

UHCCP NJ-Specific 2016 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	77.47%	R
Total Medicaid - 45-64 years	85.06%	R
Total Medicaid - 65+ years	77.22%	R
Total Medicaid - Total	80.18%	R
Dual Eligibles - 20-44 years	85.71%	R
Dual Eligibles - 45-64 years	83.86%	R
Dual Eligibles - 65+ years	67.55%	R
Dual Eligibles - Total	70.55%	R
Disabled - 20-44 years	75.14%	R
Disabled - 45-64 years	91.57%	R
Disabled - 65+ years	85.21%	R
Disabled - Total	84.19%	R
Other Low Income - 20-44 years	77.73%	R
Other Low Income - 45-64 years	83.40%	R
Other Low Income - 65+ years	82.61%	R
Other Low Income - Total	79.67%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	97.42%	R
Total Medicaid - 25 months - 6 years	93.34%	R
Total Medicaid - 7-11 years	95.08%	R
Total Medicaid - 12-19 years	92.93%	R
Total Medicaid - 12 months -19 years	93.94%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	100.00%	R
Dual Eligibles - 12-19 years	100.00%	R
Total Dual Eligibles - 12 months -19 years	100.00%	R
Disabled - 12-24 months	87.92%	R
Disabled - 25 months - 6 years	92.81%	R
Disabled - 7-11 years	94.85%	R
Disabled - 12-19 years	91.05%	R

UHCCP NJ-Specific 2016 Performance Measure	Rate	Status
Total Disabled - 12 months -19 years	92.42%	R
Other Low Income - 12-24 months	97.56%	R
Other Low Income - 25 months - 6 years	93.35%	R
Other Low Income - 7-11 years	95.09%	R
Other Low Income - 12-19 years	93.06%	R
Total Other Low Income - 12 months -19 years	94.01%	R
Preventative Dental Visit		
Total - 2-3 Years	42.65%	R
Total - 4-6 Years	66.71%	R
Total - 7-10 Years	69.31%	R
Total - 11-14 Years	63.42%	R
Total - 15-18 Years	52.07%	R
Total - 19-21 Years	36.28%	R
Total - 22-34 Years	33.82%	R
Total - 35-64 Years	32.92%	R
Total - 65+ Years	20.23%	R
Total - Total	48.78%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	NA	R
Dual Eligibles - 22-34 Years	47.83%	R
Dual Eligibles - 35-64 Years	34.46%	R
Dual Eligibles - 65+ Years	22.95%	R
Dual Eligibles - Total	25.15%	R
Disabled - 2-3 Years	38.33%	R
Disabled - 4-6 Years	56.90%	R
Disabled - 7-10 Years	58.95%	R
Disabled - 11-14 Years	54.10%	R
Disabled - 15-18 Years	43.40%	R
Disabled - 19-21 Years	31.14%	R
Disabled - 22-34 Years	29.52%	R

UHCCP NJ-Specific 2016 Performance Measure	Rate	Status
Disabled - 35-64 Years	28.50%	R
Disabled - 65+ Years	17.94%	R
Disabled - Total	34.17%	R
Other Low Income - 2-3 Years	42.74%	R
Other Low Income - 4-6 Years	67.02%	R
Other Low Income - 7-10 Years	69.76%	R
Other Low Income - 11-14 Years	63.94%	R
Other Low Income - 15-18 Years	52.65%	R
Other Low Income - 19-21 Years	37.14%	R
Other Low Income - 22-34 Years	34.33%	R
Other Low Income - 35-64 Years	33.72%	R
Other Low Income - 65+ Years	21.74%	R
Other Low Income - Total	50.45%	R

NA – No members in denominator

UHCCP HEDIS 2017 Performance Measures

UHCCP HEDIS 2017 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	68.86%	R
Combination 3	61.80%	R
Combination 9	31.14%	R
Lead Screening in Children (LSC)	81.02%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	59.74%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	74.72%	R
Adolescent Well-Care Visits (AWC)	63.21%	R
Breast Cancer Screening (BCS)	58.89%	R
Cervical Cancer Screening (CCS)	64.69%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	87.78%	R
HbA1c Poor Control (>9.0%)[1]	35.00%	R
HbA1c Control (<8.0%)	55.69%	R
HbA1c Control (<7.0%) for a Selected Population	40.21%	R
Eye Exam	58.75%	R
Medical Attention for Nephropathy	90.00%	R
Blood Pressure Controlled <140/90 mm Hg	55.42%	R
Controlling High Blood Pressure (CBP)	56.69%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	83.94%	R
Postpartum Care	65.69%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	56.69%	R
Immunizations For Adolescents (IMA)		
Meningococcal	86.37%	R
Tdap/Td	94.40%	R
HPV[3]	20.19%	R
Combination 1	84.91%	R
Combination 2	18.00%	R
Appropriate testing for children with pharyngitis (CWP)	80.26%	R
Chlamydia Screening (CHL)		
16-20	57.32%	R

UHCCP HEDIS 2017 Performance Measure	Rate	Status
21-24	63.37%	R
Total	60.02%	R
BMI assessment for children/adolescents (WCC)		
BMI percentile - 3-11 Years	76.63%	R
BMI percentile - 12-17 Years	71.53%	R
BMI percentile - Total	74.87%	R
Counseling for Nutrition - 3-11 Years	72.41%	R
Counseling for Nutrition - 12-17 Years	70.80%	R
Counseling for Nutrition - Total	71.86%	R
Counseling for Physical Activity - 3-11 Years	59.00%	R
Counseling for Physical Activity - 12-17 Years	70.80%	R
Counseling for Physical Activity - Total	63.07%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	39.52%	R
Continuation and Maintenance Phase	44.08%	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	67.43%	R
7 Day Followup	60.00%	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Adult BMI Assessment (ABA)	90.41%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	91.16%	R
Digoxin	52.91%	R
Diuretics	90.09%	R
Total	90.45%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	98.12%	R
25 months - 6 years	93.56%	R
7-11 years	96.09%	R
12-19 years	94.18%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	50.88%	R

UHCCP HEDIS 2017 Performance Measure	Rate	Status
12-18 Years - 50% Compliance	50.34%	R
19-50 Years - 50% Compliance	61.30%	R
51-64 Years - 50% Compliance	75.32%	R
Total - 50% Compliance	56.82%	R
5-11 Years - 75% Compliance	25.67%	R
12-18 Years - 75% Compliance	29.04%	R
19-50 Years - 75% Compliance	40.77%	R
51-64 Years - 75% Compliance	50.64%	R
Total - 75% Compliance	33.93%	R
Annual Dental Visit (ADV)		
Total - 2-3 Years	46.36%	R
Total - 4-6 Years	72.14%	R
Total - 7-10 Years	75.10%	R
Total - 11-14 Years	70.62%	R
Total - 15-18 Years	61.17%	R
Total - 19-20 Years	46.77%	R
Total - Total	66.28%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
Total Medicaid - < 1 Year	864.14	R
Total Medicaid - 1-9 Years	387.50	R
Total Medicaid - 10-19 Years	271.91	R
Total Medicaid - 20-44 Years	341.38	R
Total Medicaid - 45-64 Years	585.77	R
Total Medicaid - 65-74 Years	866.76	R
Total Medicaid - 75-84 Years	846.88	R
Total Medicaid - 85+ Years	714.27	R
Total Medicaid - Unknown	NA	R
Total Medicaid - Total	399.51	R
Dual-Eligibles - < 1 Year	NA	R
Dual-Eligibles - 1-9 Years	NA	R
Dual-Eligibles - 10-19 Years	NA	R
Dual-Eligibles - 20-44 Years	536.80	R
Dual-Eligibles - 45-64 Years	920.08	R
Dual-Eligibles - 65-74 Years	961.74	R

UHCCP HEDIS 2017 Performance Measure	Rate	Status
Dual-Eligibles - 75-84 Years	997.93	R
Dual-Eligibles - 85+ Years	925.51	R
Dual-Eligibles - Unknown	NA	R
Dual-Eligibles - Total	921.77	R
Disabled - < 1 Year	1,107.92	R
Disabled - 1-9 Years	506.94	R
Disabled - 10-19 Years	311.20	R
Disabled - 20-44 Years	364.41	R
Disabled - 45-64 Years	821.56	R
Disabled - 65-74 Years	702.73	R
Disabled - 75-84 Years	633.26	R
Disabled - 85+ Years	471.55	R
Disabled - Unknown	NA	R
Disabled - Total	556.13	R
Other Low Income - < 1 Year	861.85	R
Other Low Income - 1-9 Years	384.20	R
Other Low Income - 10-19 Years	269.81	R
Other Low Income - 20-44 Years	338.68	R
Other Low Income - 45-64 Years	533.74	R
Other Low Income - 65-74 Years	817.50	R
Other Low Income - 75-84 Years	1,073.86	R
Other Low Income - 85+ Years	1,429.69	R
Other Low Income - Unknown	NA	R
Other Low Income - Total	378.10	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	79.00	R
Total - 1-9 Years	42.83	R
Total - 10-19 Years	35.13	R
Total - 20-44 Years	71.30	R
Total - 45-64 Years	63.42	R
Total - 65-74 Years	50.64	R
Total - 75-84 Years	49.82	R
Total - 85+ Years	46.40	R
Total - Unknown Years	NA	R

UHCCP HEDIS 2017 Performance Measure	Rate	Status
Total - Total Years	53.27	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	NA	R
Dual Eligibles - 20-44 Years	115.30	R
Dual Eligibles - 45-64 Years	113.47	R
Dual Eligibles - 65-74 Years	60.43	R
Dual Eligibles - 75-84 Years	62.28	R
Dual Eligibles - 85+ Years	56.42	R
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	78.95	R
Disabled - <1 Years	135.87	R
Disabled - 1-9 Years	78.32	R
Disabled - 10-19 Years	58.83	R
Disabled - 20-44 Years	105.07	R
Disabled - 45-64 Years	118.05	R
Disabled - 65-74 Years	33.66	R
Disabled - 75-84 Years	32.42	R
Disabled - 85+ Years	34.57	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	90.67	R
Other Low Income - <1 Years	78.47	R
Other Low Income - 1-9 Years	41.85	R
Other Low Income - 10-19 Years	33.86	R
Other Low Income - 20-44 Years	68.66	R
Other Low Income - 45-64 Years	52.28	R
Other Low Income - 65-74 Years	48.42	R
Other Low Income - 75-84 Years	51.14	R
Other Low Income - 85+ Years	85.94	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	49.99	R

[1] HbA1c Poor Control is an inverted measure. Higher rates for HbA1c Poor Control indicate poorer performance.

[2] Follow-up After Hospitalization and Follow-Up After Emergency Department Visit for Mental Illness are only applicable to members who receive a behavioral health benefit.

This is limited to the MLTSS and DDD members.

[3] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.
NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

UHCCP NJ-Specific 2017 Performance Measures

UHCCP NJ-Specific 2017 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	77.67%	R
Total Medicaid - 45-64 years	85.67%	R
Total Medicaid - 65+ years	93.35%	R
Total Medicaid - Total	81.29%	R
Dual Eligibles - 20-44 years	94.54%	R
Dual Eligibles - 45-64 years	97.72%	R
Dual Eligibles - 65+ years	97.80%	R
Dual Eligibles - Total	97.52%	R
Disabled - 20-44 years	77.37%	R
Disabled - 45-64 years	91.40%	R
Disabled - 65+ years	87.41%	R
Disabled - Total	85.50%	R
Other Low Income - 20-44 years	77.60%	R
Other Low Income - 45-64 years	83.96%	R
Other Low Income - 65+ years	94.87%	R
Other Low Income - Total	79.84%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	98.12%	R
Total Medicaid - 25 months - 6 years	93.56%	R
Total Medicaid - 7-11 years	96.09%	R
Total Medicaid - 12-19 years	94.18%	R
Total Medicaid - 12 months -19 years	94.74%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	NA	R
Dual Eligibles - 12-19 years	NA	R
Total Dual Eligibles - 12 months -19 years	NA	R
Disabled - 12-24 months	95.83%	R
Disabled - 25 months - 6 years	93.91%	R
Disabled - 7-11 years	95.99%	R
Disabled - 12-19 years	92.06%	R

UHCCP NJ-Specific 2017 Performance Measure	Rate	Status
Total Disabled - 12 months -19 years	93.67%	R
Other Low Income - 12-24 months	98.15%	R
Other Low Income - 25 months - 6 years	93.55%	R
Other Low Income - 7-11 years	96.09%	R
Other Low Income - 12-19 years	94.31%	R
Total Other Low Income - 12 months -19 years	94.78%	R
Preventative Dental Visit		
Total - 2-3 Years	45.79%	R
Total - 4-6 Years	70.39%	R
Total - 7-10 Years	72.73%	R
Total - 11-14 Years	67.41%	R
Total - 15-18 Years	56.22%	R
Total - 19-21 Years	40.86%	R
Total - 22-34 Years	36.11%	R
Total - 35-64 Years	35.89%	R
Total - 65+ Years	24.65%	R
Total - Total	49.21%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	37.59%	R
Dual Eligibles - 22-34 Years	37.00%	R
Dual Eligibles - 35-64 Years	38.69%	R
Dual Eligibles - 65+ Years	25.14%	R
Dual Eligibles - Total	30.44%	R
Disabled - 2-3 Years	43.15%	R
Disabled - 4-6 Years	59.59%	R
Disabled - 7-10 Years	61.14%	R
Disabled - 11-14 Years	57.08%	R
Disabled - 15-18 Years	46.58%	R
Disabled - 19-21 Years	34.81%	R
Disabled - 22-34 Years	31.35%	R

UHCCP NJ-Specific 2017 Performance Measure	Rate	Status
Disabled - 35-64 Years	30.59%	R
Disabled - 65+ Years	19.77%	R
Disabled - Total	36.50%	R
Other Low Income - 2-3 Years	45.85%	R
Other Low Income - 4-6 Years	70.74%	R
Other Low Income - 7-10 Years	73.22%	R
Other Low Income - 11-14 Years	67.94%	R
Other Low Income - 15-18 Years	56.83%	R
Other Low Income - 19-21 Years	41.68%	R
Other Low Income - 22-34 Years	36.56%	R
Other Low Income - 35-64 Years	36.18%	R
Other Low Income - 65+ Years	16.13%	R
Other Low Income - Total	53.15%	R

NA – Insufficient membership to report a rate (<30 members in denominator).

UHCCP Quality Improvement Projects

UHCCP QIP 1: Identification and Management of Childhood Obesity (Ages 12-17)

QIP 1: June 2016 Project Year 2 Update (2) Review

UHC - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF CHILDHOOD OBESITY (AGES 12-17)				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	60
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: September 2016 Sustainability Year Update (1) Review

UHC - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF CHILDHOOD OBESITY (AGES 12-17)				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	72.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: June 2017 Sustainability Year Update (2) Review

UHC - SUMMARY SCORING				
IDENTIFICATION AND MANAGEMENT OF CHILDHOOD OBESITY (AGES 12-17)				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	72.5
Review Element 10 - Sustainability of Documented Improvement	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	10
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*82.5*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

UHCCP QIP 2: Preterm Births in Hudson County, NJ

QIP 2: June 2016 Project Year 1 Update (2) Review

United Healthcare of New Jersey - SUMMARY SCORING				
PRETERM BIRTHS IN HUDSON COUNTY, NJ				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2016 Project Year 2 Update (1) Review

United Healthcare Community Plan of New Jersey- SUMMARY SCORING				
PRETERM BIRTHS IN HUDSON COUNTY, NJ				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	60
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: June 2017 Project Year 2 Update (2) Review

UnitedHealthcare Community Plan of New Jersey- SUMMARY SCORING				
PRETERM BIRTHS IN HUDSON COUNTY, NJ				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	47.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2017 Project Sustainability Year 3 Update (1) Review

UnitedHealthcare Community Plan of New Jersey- SUMMARY SCORING				
PRETERM BIRTHS IN HUDSON COUNTY, NJ				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	50
Review Element 10 - Sustainability of Documented Improvement	M	100	20%	20
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	70
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

UHCCP QIP 3: Preventing Recurrent Falls in MLTSS Members with History of Falls

QIP 3: June 2016 Project Baseline Update Review

UNITED HEALTHCARE COMMUNITY PLAN - SUMMARY SCORING				
PREVENTING RECURRENT FALLS IN MLTSS MEMBERS WITH HISTORY OF FALLS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	52.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT – Current available points 60			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2016 Project Year 1 Update (1) Review

UNITED HEALTHCARE COMMUNITY PLAN - SUMMARY SCORING				
PREVENTING RECURRENT FALLS IN MLTSS MEMBERS WITH HISTORY OF FALLS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: June 2017 Project Year 1 Update (2) Review

UNITED HEALTHCARE COMMUNITY PLAN - SUMMARY SCORING				
PREVENTING RECURRENT FALLS IN MLTSS MEMBERS WITH HISTORY OF FALLS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	NM	0	20%	0
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	55
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2017 Project Year2 Update (1) Review

UNITED HEALTHCARE COMMUNITY PLAN - SUMMARY SCORING				
PREVENTING RECURRENT FALLS IN MLTSS MEMBERS WITH HISTORY OF FALLS				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	70
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

UHCCP QIP 4: Early Intervention for Children in Lead Case Management (Age Birth to 3 Years Old)

QIP 4: September 2017 Proposal Review

United Healthcare Community Plan of New Jersey - SUMMARY SCORING				
EARLY INTERVENTION FOR CHILDREN IN LEAD CASE MANAGEMENT (AGE BIRTH TO 3 YEARS OLD)				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	Met	100	5%	5
Review Element 2 - Study Question (AIM Statement)	Partial	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	Met	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	Met	100	10%	10
Review Element 6 - Data Collection Procedures	Met	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	Partial	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

UHCCP Care Management Audits

UHCCP Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2015 (n=101)	2016 (n=102)	% Point Change	2015 (n=89)	2016 (n=66)	% Point Change	2015 (n=100)	2016 (n=100)	% Point Change
Identification	90%	92%	+2	100%	100%	0	100%	100%	0
Outreach	86%	86%	0	99%	98%	-1	100%	99%	-1
Preventive Services	92%	87%	-5	95%	90%	-5	97%	96%	-1
Continuity of Care	98%	99%	+1	89%	100%	+11	100%	100%	0
Coordination of Services	99%	100%	+1	99%	99%	0	100%	99%	-1

UHCCP MLTSS HCBS Care Management Audits: July 2014–June 2017

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
#8. Initial Plan of Care established within 30 days of enrollment into MLTSS/HCBS.[1]	Group A&B	37	34	91.9%							
	Group C	46	32	69.6%	76	63	82.9%	78	68	87.2%	4.3
	Group D	18	7	38.9%	15	12	80.0%	22	19	86.4%	6.4
	Group E										
	Total	101	73	72.3%	91	75	82.4%	100	87	87.0%	4.6
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group A&B										
	Group C				13	12	92.3%	0	0	N/A	N/A
	Group D				3	3	100.0%	0	0	N/A	N/A
	Group E							6	5	83.3%	
	Total				16	15	93.8%	6	5	83.3%	-10.5
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group A&B										
	Group C				8	4	50.0%	4	3	75.0%	25.0
	Group D				2	2	100.0%	1	0	0.0%	-100.0
	Group E							2	0	0.0%	
	Total				10	6	60.0%	7	3	42.9%	-17.1
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	Group A&B	37	32	86.5%							
	Group C	33	31	93.9%	67	67	100.0%	63	54	85.7%	-14.3
	Group D	15	14	93.3%	14	13	92.9%	19	18	94.7%	1.8
	Group E							18	18	100.0%	
	Total	85	77	90.6%	81	80	98.8%	100	90	90.0%	-8.8
#11. Plans of Care developed using "person-centered principles" [5]	Group A&B	37	13	35.1%							
	Group C	43	37	86.0%	76	39	51.3%	63	46	73.0%	21.7
	Group D	19	15	78.9%	15	9	60.0%	19	16	84.2%	24.2
	Group E							18	9	50.0%	
	Total	99	65	65.7%	91	48	52.7%	100	71	71.0%	18.3
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group A&B	22	20	90.9%							
	Group C	25	19	76.0%	37	33	89.2%	33	25	75.8%	-13.4
	Group D	18	15	83.3%	14	13	92.9%	14	13	92.9%	0.0
	Group E							13	10	76.9%	
	Total	65	54	83.1%	51	46	90.2%	60	48	80.0%	-10.2
#16. Member training on identifying/reporting critical	Group A&B										
	Group C				76	68	89.5%	63	50	79.4%	-10.1

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
incidents	Group D				15	13	86.7%	19	17	89.5%	2.8
	Group E							18	17	94.4%	
	Total				91	81	89.0%	100	84	84.0%	-5.0

[1]From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.
[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 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]Members are excluded from this measure if they do not have a completed NJCA or a completed POC
[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.
[6]Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017. In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing
Group A & B – Current Members converted to MLTSS on 7/1/2014. These members were only included in the initial review period.
Group C - Members New to Managed Care and Newly Eligible to MLTSS
Group D - Current Members Newly Enrolled to MLTSS

WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

WCHP 2016 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year	Subject to Review[1]	Met[2]	Not Met	N/A	% Met[3]	Deficiency Status		
								Prior	Resolved	New
Access	8	6	8	7	1	0	88%	1	0	0
Quality Assessment and Performance Improvement	10	8	10	10	0	0	100%	0	1	0
Quality Management	13	5	13	12	1	0	92%	1	6	0
Efforts to Reduce Healthcare Disparities	4	0	4	1	3	0	25%	3	0	0
Committee Structure	9	4	9	9	0	0	100%	0	4	0
Programs for the Elderly and Disabled	44	25	44	32	12	0	73%	12	6	0
Provider Training and Performance	11	7	11	10	1	0	91%	1	2	0
Satisfaction	4	1	4	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	6	8	8	0	0	100%	0	1	0
Care Management and Continuity of Care	37	24	37	30	7	0	81%	5	6	2
Credentialing and Recredentialing	10	8	10	9	1	0	90%	1	0	0
Utilization Management	22	20	22	21	1	0	95%	1	0	0
Administration and Operations	13	12	13	13	0	0	100%	0	0	0
Management Information Systems	18	14	18	17	0	1	100%	0	3	0
TOTAL	**211**	**140**	**211**	**183**	**27**	**1**	**87%**	**25**	**29**	**2**

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

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

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

WCHP 2017 Annual Assessment of MCO Operations

Review Category	Total Elements	Met Prior Year[1]	Subject to Review[2]	Subject to Review and Met[3]	Total Met[4]	Not Met	N/A	% Met[5]	Deficiency Status		
									Prior	Resolved	New
Access	8	7	2	1	7	1	0	88%	1	0	0
Quality Assessment and Performance Improvement	10	10	0	0	10	0	0	100%	0	0	0
Quality Management	17	12	6	5	16	1	0	94%	1	0	0
Efforts to Reduce Healthcare Disparities	5	1	5	4	4	1	0	80%	1	2	0
Committee Structure	9	9	2	2	9	0	0	100%	0	0	0
Programs for the Elderly and Disabled	44	32	14	14	44	0	0	100%	0	12	0
Provider Training and Performance	11	10	3	3	11	0	0	100%	0	1	0
Satisfaction	4	4	0	0	4	0	0	100%	0	0	0
Enrollee Rights and Responsibilities	8	8	3	3	8	0	0	100%	0	0	0
Care Management and Continuity of Care	37	30	17	17	37	0	0	100%	0	7	0
Credentialing and Recredentialing	10	9	3	3	10	0	0	100%	0	1	0
Utilization Management	22	21	3	2	21	1	0	95%	1	0	0
Administration and Operations	13	13	2	2	13	0	0	100%	0	0	0
Management Information Systems	18	17	5	4	17	0	1	100%	0	0	0
TOTAL	**216**	**183**	**65**	**60**	**211**	**4**	**1**	**98%**	**4**	**23**	**0**

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

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

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

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

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

WCHP Performance Measures

WCHP HEDIS 2016 Performance Measures

WCHP HEDIS 2016 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	64.97%	R
Combination 3	58.63%	R
Lead Screening in Children (LSC)	71.57%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	51.43%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	76.78%	R
Adolescent Well-Care Visits (AWC)	56.94%	R
Breast Cancer Screening (BCS)	NA	R
Cervical Cancer Screening (CCS)	45.14%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	85.84%	R
HbA1c Poor Control (>9.0%)[1]	43.06%	R
HbA1c Control (<8.0%)	47.94%	R
HbA1c Control (<7.0%) for a Selected Population	35.68%	R
Eye Exam	55.22%	R
Medical Attention for Nephropathy	88.90%	R
Blood Pressure Controlled <140/90 mm Hg	54.74%	R
Controlling High Blood Pressure (CBP)	52.65%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	78.24%	R
Postpartum Care	49.31%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	55.09%	R
Immunizations For Adolescents (IMA)		
Meningococcal	76.81%	R
Tdap/Td	84.78%	R
Combination 1	74.15%	R
Appropriate testing for children with pharyngitis (CWP)	67.98%	R
Chlamydia Screening (CHL)		
16-20	52.11%	R
21-24	61.67%	R

WCHP HEDIS 2016 Performance Measure	Rate	Status
Total	56.84%	R
BMI assessment for children/adolescents (WCC)		
3-11	57.78%	R
12-17	61.24%	R
Total	58.90%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	33.33%	R
Continuation and Maintenance Phase	NA	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Adult BMI Assessment (ABA)	72.04%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	92.33%	R
Digoxin	NA	R
Diuretics	90.44%	R
Total	91.28%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	90.28%	R
25 months - 6 years	90.20%	R
7-11 years	NA	R
12-19 years	NA	R
Human Papillomavirus Vaccine for Female Adolescents (HPV)	22.04%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	NA	R
5-11 Years - 75% Compliance	NA	R
12-18 Years - 50% Compliance	NA	R
12-18 Years - 75% Compliance	NA	R
19-50 Years - 50% Compliance	NA	R
19-50 Years - 75% Compliance	NA	R
51-64 Years - 50% Compliance	NA	R
51-64 Years - 75% Compliance	NA	R
Total - 50% Compliance	NA	R
Total - 75% Compliance	NA	R

WCHP HEDIS 2016 Performance Measure	Rate	Status
Annual Dental Visit (ADV)		
Total - 2-3 Years	47.36%	R
Total - 4-6 Years	61.48%	R
Total - 7-10 Years	65.01%	R
Total - 11-14 Years	59.51%	R
Total - 15-18 Years	51.86%	R
Total - 19-20 Years	25.64%	R
Total – Total	56.84%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
<1 Year - Total Medicaid	532.26	R
1-9 Years - Total Medicaid	274.30	R
10-19 Years - Total Medicaid	201.32	R
20-44 Years - Total Medicaid	270.24	R
45-64 Years - Total Medicaid	572.76	R
65-74 Years - Total Medicaid	953.83	R
75-84 Years - Total Medicaid	1,081.82	R
85+ Years - Total Medicaid	1,141.10	R
Unknown - Total Medicaid	NA	R
Total - Total Medicaid	434.45	R
<1 Year - Dual-Eligibles	1,000.00	R
1-9 Years - Dual-Eligibles	NA	R
10-19 Years - Dual-Eligibles	114.29	R
20-44 Years - Dual-Eligibles	541.15	R
45-64 Years - Dual-Eligibles	898.83	R
65-74 Years - Dual-Eligibles	989.89	R
75-84 Years - Dual-Eligibles	1,135.08	R
85+ Years - Dual-Eligibles	1,182.78	R
Unknown - Dual-Eligibles	NA	R
Total - Dual-Eligibles	1,001.33	R
<1 Year - Disabled	368.77	R
1-9 Years - Disabled	274.71	R
10-19 Years - Disabled	184.03	R
20-44 Years - Disabled	394.05	R
45-64 Years - Disabled	887.63	R

WCHP HEDIS 2016 Performance Measure	Rate	Status
65-74 Years - Disabled	713.44	R
75-84 Years - Disabled	598.72	R
85+ Years - Disabled	540.59	R
Unknown - Disabled	NA	R
Total - Disabled	587.83	R
< 1 Year - Other Low Income	535.60	R
1-9 Years - Other Low Income	274.29	R
10-19 Years - Other Low Income	202.31	R
20-44 Years - Other Low Income	247.14	R
45-64 Years - Other Low Income	449.86	R
65-74 Years - Other Low Income	406.02	R
75-84 Years - Other Low Income	0.00	R
85+ Years - Other Low Income	0.00	R
Unknown - Other Low Income	NA	R
Total - Other Low Income	293.09	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	88.93	R
Total - 1-9 Years	45.46	R
Total - 10-19 Years	30.73	R
Total - 20-44 Years	69.93	R
Total - 45-64 Years	57.74	R
Total - 65-74 Years	41.12	R
Total - 75-84 Years	41.92	R
Total - 85+ Years	49.71	R
Total - Unknown Years	NA	R
Total - Total Years	53.48	R
Dual Eligibles - <1 Years	0.00	R
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	0.00	R
Dual Eligibles - 20-44 Years	90.24	R
Dual Eligibles - 45-64 Years	79.29	R
Dual Eligibles - 65-74 Years	42.35	R
Dual Eligibles - 75-84 Years	42.75	R
Dual Eligibles - 85+ Years	51.66	R

WCHP HEDIS 2016 Performance Measure	Rate	Status
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	55.15	R
Disabled - <1 Years	89.7	R
Disabled - 1-9 Years	55.46	R
Disabled - 10-19 Years	43.38	R
Disabled - 20-44 Years	123.65	R
Disabled - 45-64 Years	108.27	R
Disabled - 65-74 Years	32.58	R
Disabled - 75-84 Years	34.58	R
Disabled - 85+ Years	21.59	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	86.29	R
Other Low Income - <1 Years	88.97	R
Other Low Income - 1-9 Years	45.2	R
Other Low Income - 10-19 Years	30.03	R
Other Low Income - 20-44 Years	65.05	R
Other Low Income - 45-64 Years	44.76	R
Other Low Income - 65-74 Years	37.59	R
Other Low Income - 75-84 Years	0.00	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	50.01	R

[1] HbA1c Poor Control is an inverted measure. Lower rates indicate better performance.

[2] This measure is only applicable for MLTSS and DDD members.

NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others)

WCHP NJ-Specific 2016 Performance Measures

WCHP NJ-Specific 2016 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	66.86%	R
Total Medicaid - 45-64 years	81.92%	R
Total Medicaid - 65+ years	91.57%	R
Total Medicaid - Total	79.37%	R
Dual Eligibles - 20-44 years	81.91%	R
Dual Eligibles - 45-64 years	90.28%	R
Dual Eligibles - 65+ years	92.35%	R
Dual Eligibles - Total	91.15%	R
Disabled - 20-44 years	66.17%	R
Disabled - 45-64 years	88.97%	R
Disabled - 65+ years	84.20%	R
Disabled - Total	80.33%	R
Other Low Income - 20-44 years	65.45%	R
Other Low Income - 45-64 years	77.15%	R
Other Low Income - 65+ years	71.43%	R
Other Low Income - Total	70.29%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	90.28%	R
Total Medicaid - 25 months - 6 years	90.20%	R
Total Medicaid - 7-11 years	80.95%	R
Total Medicaid - 12-19 years	79.17%	R
Total Medicaid - 12 months -19 years	90.10%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	NA	R
Dual Eligibles - 12-19 years	NA	R
Total Dual Eligibles - 12 months -19 years	NA	R
Disabled - 12-24 months	46.67%	R
Disabled - 25 months - 6 years	79.69%	R
Disabled - 7-11 years	100.00%	R
Disabled - 12-19 years	NA	R
Total Disabled - 12 months -19 years	73.75%	R
Other Low Income - 12-24 months	91.41%	R

WCHP NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income - 25 months - 6 years	90.39%	R
Other Low Income - 7-11 years	80.00%	R
Other Low Income - 12-19 years	79.17%	R
Total Other Low Income - 12 months -19 years	90.42%	R
Preventive Dental Visit		
Total - 2-3 Years	47.37%	R
Total - 4-6 Years	59.62%	R
Total - 7-10 Years	62.77%	R
Total - 11-14 Years	56.69%	R
Total - 15-18 Years	47.62%	R
Total - 19-21 Years	23.54%	R
Total - 22-34 Years	26.80%	R
Total - 35-64 Years	30.14%	R
Total - 65+ Years	21.60%	R
Total - Total	36.94%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	33.33%	R
Dual Eligibles - 22-34 Years	31.88%	R
Dual Eligibles - 35-64 Years	32.11%	R
Dual Eligibles - 65+ Years	22.22%	R
Dual Eligibles - Total	24.81%	R
Disabled - 2-3 Years	38.46%	R
Disabled - 4-6 Years	56.86%	R
Disabled - 7-10 Years	57.14%	R
Disabled - 11-14 Years	43.06%	R
Disabled - 15-18 Years	39.47%	R
Disabled - 19-21 Years	22.22%	R
Disabled - 22-34 Years	25.74%	R
Disabled - 35-64 Years	28.79%	R
Disabled - 65+ Years	15.48%	R
Disabled - Total	28.39%	R

WCHP NJ-Specific 2016 Performance Measure	Rate	Status
Other Low Income - 2-3 Years	47.46%	R
Other Low Income - 4-6 Years	59.69%	R
Other Low Income - 7-10 Years	63.05%	R
Other Low Income - 11-14 Years	57.52%	R
Other Low Income - 15-18 Years	48.17%	R
Other Low Income - 19-21 Years	23.70%	R
Other Low Income - 22-34 Years	26.51%	R
Other Low Income - 35-64 Years	29.92%	R
Other Low Income - 65+ Years	33.33%	R
Other Low Income - Total	42.70%	R

NA – No members in denominator

WCHP HEDIS 2017 Performance Measures

WCHP HEDIS 2017 Performance Measure	Rate	Status
Childhood Immunization (CIS)		
Combination 2	61.80%	R
Combination 3	54.74%	R
Combination 9	28.47%	R
Lead Screening in Children (LSC)	74.70%	R
Well-Child Visits in the First 15 Months of Life -- 6 or More Visits (W15)	54.67%	R
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)	78.03%	R
Adolescent Well-Care Visits (AWC)	60.00%	R
Breast Cancer Screening (BCS)	58.10%	R
Cervical Cancer Screening (CCS)	48.42%	R
Comprehensive Diabetes Care (CDC)		
HbA1c Testing	86.42%	R
HbA1c Poor Control (>9.0%)[1]	37.58%	R
HbA1c Control (<8.0%)	52.32%	R
HbA1c Control (<7.0%) for a Selected Population	36.42%	R
Eye Exam	54.11%	R
Medical Attention for Nephropathy	90.53%	R
Blood Pressure Controlled <140/90 mm Hg	48.21%	R
Controlling High Blood Pressure (CBP)	41.46%	R
Prenatal and Postpartum Care (PPC)		
Timeliness of Prenatal Care	80.05%	R
Postpartum Care	60.83%	R
Frequency of Ongoing Prenatal Care -- 81+ Percent of Expected Prenatal Visits (FPC)	58.88%	R
Immunizations For Adolescents (IMA)		
Meningococcal	84.18%	R
Tdap/Td	90.75%	R
HPV[3]	19.71%	R
Combination 1	82.00%	R
Combination 2	17.52%	R
Appropriate testing for children with pharyngitis (CWP)	66.78%	R
Chlamydia Screening (CHL)		
16-20	55.78%	R

WCHP HEDIS 2017 Performance Measure	Rate	Status
21-24	67.70%	R
Total	61.52%	R
BMI assessment for children/adolescents (WCC)		
BMI percentile - 3-11 Years	66.55%	R
BMI percentile - 12-17 Years	69.05%	R
BMI percentile - Total	67.32%	R
Counseling for Nutrition - 3-11 Years	64.79%	R
Counseling for Nutrition - 12-17 Years	69.84%	R
Counseling for Nutrition - Total	66.34%	R
Counseling for Physical Activity - 3-11 Years	45.42%	R
Counseling for Physical Activity - 12-17 Years	56.35%	R
Counseling for Physical Activity - Total	48.78%	R
Follow up care for children prescribed ADHD medication (ADD)		
Initiation Phase	39.34%	R
Continuation and Maintenance Phase	NA	R
Follow-up after hospitalization for mental illness (FUH)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[2]		
30 Day Followup	NA	R
7 Day Followup	NA	R
Adult BMI Assessment (ABA)	70.15%	R
Annual Monitoring for Patients on Persistent Medications (MPM)		
ACE Inhibitors or ARBs	92.57%	R
Digoxin	NA	R
Diuretics	91.19%	R
Total	91.82%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
12-24 months	94.46%	R
25 months - 6 years	91.95%	R
7-11 years	96.16%	R
12-19 years	93.30%	R
Medication Management for People With Asthma (MMA)		
5-11 Years - 50% Compliance	41.67%	R

WCHP HEDIS 2017 Performance Measure	Rate	Status
12-18 Years - 50% Compliance	48.72%	R
19-50 Years - 50% Compliance	59.81%	R
51-64 Years - 50% Compliance	79.49%	R
Total - 50% Compliance	60.66%	R
5-11 Years - 75% Compliance	20.83%	R
12-18 Years - 75% Compliance	23.08%	R
19-50 Years - 75% Compliance	42.06%	R
51-64 Years - 75% Compliance	46.15%	R
Total - 75% Compliance	36.76%	R
Annual Dental Visit (ADV)		
Total - 2-3 Years	50.90%	R
Total - 4-6 Years	65.36%	R
Total - 7-10 Years	69.90%	R
Total - 11-14 Years	66.83%	R
Total - 15-18 Years	56.74%	R
Total - 19-20 Years	37.66%	R
Total - Total	61.64%	R
Ambulatory Care - Outpatient Visits per Thousand Member Months (AMB)		
Total Medicaid - < 1 Year	595.45	R
Total Medicaid - 1-9 Years	305.10	R
Total Medicaid - 10-19 Years	236.31	R
Total Medicaid - 20-44 Years	305.89	R
Total Medicaid - 45-64 Years	625.61	R
Total Medicaid - 65-74 Years	861.64	R
Total Medicaid - 75-84 Years	827.61	R
Total Medicaid - 85+ Years	835.10	R
Total Medicaid - Unknown	NA	R
Total Medicaid - Total	390.22	R
Dual-Eligibles - < 1 Year	NA	R
Dual-Eligibles - 1-9 Years	NA	R
Dual-Eligibles - 10-19 Years	NA	R
Dual-Eligibles - 20-44 Years	1,073.03	R
Dual-Eligibles - 45-64 Years	1,613.82	R
Dual-Eligibles - 65-74 Years	1,414.93	R

WCHP HEDIS 2017 Performance Measure	Rate	Status
Dual-Eligibles - 75-84 Years	1,573.03	R
Dual-Eligibles - 85+ Years	1,756.41	R
Dual-Eligibles - Unknown	NA	R
Dual-Eligibles - Total	1,506.74	R
Disabled - < 1 Year	625.00	R
Disabled - 1-9 Years	338.97	R
Disabled - 10-19 Years	234.57	R
Disabled - 20-44 Years	508.99	R
Disabled - 45-64 Years	1,039.23	R
Disabled - 65-74 Years	755.99	R
Disabled - 75-84 Years	671.79	R
Disabled - 85+ Years	682.18	R
Disabled - Unknown	NA	R
Disabled - Total	737.28	R
Other Low Income - < 1 Year	595.21	R
Other Low Income - 1-9 Years	304.26	R
Other Low Income - 10-19 Years	236.39	R
Other Low Income - 20-44 Years	290.72	R
Other Low Income - 45-64 Years	538.48	R
Other Low Income - 65-74 Years	343.07	R
Other Low Income - 75-84 Years	0.00	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown	NA	R
Other Low Income - Total	345.86	R
Ambulatory Care - Emergency Room Visits per Thousand Member Months (AMB)		
Total - <1 Years	95.20	R
Total - 1-9 Years	49.57	R
Total - 10-19 Years	34.61	R
Total - 20-44 Years	76.22	R
Total - 45-64 Years	58.72	R
Total - 65-74 Years	39.38	R
Total - 75-84 Years	32.41	R
Total - 85+ Years	47.68	R
Total - Unknown Years	NA	R

WCHP HEDIS 2017 Performance Measure	Rate	Status
Total - Total Years	58.31	R
Dual Eligibles - <1 Years	NA	R
Dual Eligibles - 1-9 Years	NA	R
Dual Eligibles - 10-19 Years	NA	R
Dual Eligibles - 20-44 Years	174.16	R
Dual Eligibles - 45-64 Years	147.70	R
Dual Eligibles - 65-74 Years	60.05	R
Dual Eligibles - 75-84 Years	61.80	R
Dual Eligibles - 85+ Years	89.74	R
Dual Eligibles - Unknown Years	NA	R
Dual Eligibles - Total Years	88.05	R
Disabled - <1 Years	116.07	R
Disabled - 1-9 Years	59.19	R
Disabled - 10-19 Years	59.13	R
Disabled - 20-44 Years	154.09	R
Disabled - 45-64 Years	115.89	R
Disabled - 65-74 Years	32.13	R
Disabled - 75-84 Years	26.27	R
Disabled - 85+ Years	40.93	R
Disabled - Unknown Years	NA	R
Disabled - Total Years	96.79	R
Other Low Income - <1 Years	95.03	R
Other Low Income - 1-9 Years	49.33	R
Other Low Income - 10-19 Years	33.44	R
Other Low Income - 20-44 Years	70.63	R
Other Low Income - 45-64 Years	47.01	R
Other Low Income - 65-74 Years	167.88	R
Other Low Income - 75-84 Years	0.00	R
Other Low Income - 85+ Years	0.00	R
Other Low Income - Unknown Years	NA	R
Other Low Income - Total Years	54.05	R

[1] HbA1c Poor Control is an inverted measure. Higher rates for HbA1c Poor Control indicate poorer performance.

[2] Follow-up After Hospitalization and Follow-Up After Emergency Department Visit for Mental Illness are only applicable to members who receive a behavioral health benefit. This is limited to the MLTSS and DDD members.

[3] The Human Papillomavirus Vaccine for Female Adolescents (HPV) measure was retired. HPV was added as a new indicator in the Immunizations for Adolescents measure. IMA HPV numerator eligible population increased due to the addition of male adolescents for HEDIS 2017.
NA – Insufficient membership to report a rate (0 member months for the AMB measure, <30 members in denominator for all others).

WCHP NJ-Specific 2017 Performance Measures

WCHP NJ-Specific 2017 Performance Measure	Rate	Status
Adults' Access to Preventive/Ambulatory Health Services (AAP)		
Total Medicaid - 20-44 years	67.78%	R
Total Medicaid - 45-64 years	80.22%	R
Total Medicaid - 65+ years	86.17%	R
Total Medicaid - Total	74.18%	R
Dual Eligibles - 20-44 years	NA	R
Dual Eligibles - 45-64 years	NA	R
Dual Eligibles - 65+ years	97.50%	R
Dual Eligibles - Total	96.30%	R
Disabled - 20-44 years	78.12%	R
Disabled - 45-64 years	89.64%	R
Disabled - 65+ years	85.40%	R
Disabled - Total	85.43%	R
Other Low Income - 20-44 years	66.65%	R
Other Low Income - 45-64 years	77.92%	R
Other Low Income - 65+ years	NA	R
Other Low Income - Total	71.59%	R
Children and Adolescents' Access to Primary Care Practitioners (CAP)		
Total Medicaid - 12-24 months	94.46%	R
Total Medicaid - 25 months - 6 years	91.95%	R
Total Medicaid - 7-11 years	96.16%	R
Total Medicaid - 12-19 years	93.29%	R
Total Medicaid - 12 months -19 years	93.61%	R
Dual Eligibles - 12-24 months	NA	R
Dual Eligibles - 25 months - 6 years	NA	R
Dual Eligibles - 7-11 years	NA	R
Dual Eligibles - 12-19 years	NA	R
Total Dual Eligibles - 12 months -19 years	NA	R
Disabled - 12-24 months	NA	R
Disabled - 25 months - 6 years	87.88%	R
Disabled - 7-11 years	96.15%	R
Disabled - 12-19 years	90.61%	R
Total Disabled - 12 months -19 years	91.57%	R
Other Low Income - 12-24 months	94.57%	R

WCHP NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income - 25 months - 6 years	92.03%	R
Other Low Income - 7-11 years	96.16%	R
Other Low Income - 12-19 years	93.45%	R
Total Other Low Income - 12 months -19 years	93.69%	R
Preventive Dental Visit		
Total - 2-3 Years	52.15%	R
Total - 4-6 Years	64.98%	R
Total - 7-10 Years	68.66%	R
Total - 11-14 Years	63.70%	R
Total - 15-18 Years	52.14%	R
Total - 19-21 Years	28.93%	R
Total - 22-34 Years	25.58%	R
Total - 35-64 Years	29.81%	R
Total - 65+ Years	19.27%	R
Total - Total	42.41%	R
Dual Eligibles - 2-3 Years	NA	R
Dual Eligibles - 4-6 Years	NA	R
Dual Eligibles - 7-10 Years	NA	R
Dual Eligibles - 11-14 Years	NA	R
Dual Eligibles - 15-18 Years	NA	R
Dual Eligibles - 19-21 Years	NA	R
Dual Eligibles - 22-34 Years	NA	R
Dual Eligibles - 35-64 Years	NA	R
Dual Eligibles - 65+ Years	NA	R
Dual Eligibles - Total	NA	R
Disabled - 2-3 Years	NA	R
Disabled - 4-6 Years	37.50%	R
Disabled - 7-10 Years	54.29%	R
Disabled - 11-14 Years	39.71%	R
Disabled - 15-18 Years	41.05%	R
Disabled - 19-21 Years	25.00%	R
Disabled - 22-34 Years	30.56%	R
Disabled - 35-64 Years	26.68%	R
Disabled - 65+ Years	18.28%	R
Disabled - Total	27.66%	R

WCHP NJ-Specific 2017 Performance Measure	Rate	Status
Other Low Income - 2-3 Years	52.05%	R
Other Low Income - 4-6 Years	65.57%	R
Other Low Income - 7-10 Years	69.21%	R
Other Low Income - 11-14 Years	64.69%	R
Other Low Income - 15-18 Years	52.79%	R
Other Low Income - 19-21 Years	29.40%	R
Other Low Income - 22-34 Years	25.00%	R
Other Low Income - 35-64 Years	30.41%	R
Other Low Income - 65+ Years	NA	R
Other Low Income - Total	44.35%	R

NA – Insufficient membership to report a rate (<30 members in denominator).

WCHP Quality Improvement Projects

WCHP QIP 1: Improving the Identification and Management of Pediatric Obesity in the 12-17 Year Old Medicaid Population

QIP 1: June 2016 Project Year 1 Update (2) Review

WellCare - SUMMARY SCORING				
IMPROVING THE IDENTIFICATION AND MANAGEMENT OF PEDIATRIC OBESITY IN THE 12-17 YEAR OLD MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	77.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: September 2016 Project Year 2 Update (1) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
IMPROVING THE IDENTIFICATION AND MANAGEMENT OF PEDIATRIC OBESITY IN THE 12-17 YEAR OLD MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	67.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan
COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: June 2017 Project Year 2 Update (2) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
IMPROVING THE IDENTIFICATION AND MANAGEMENT OF PEDIATRIC OBESITY IN THE 12-17 YEAR OLD MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	72.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 1: October 2017 Project Sustainability Year 3 Update (1) Review

WellCare Health Plans of New Jersey, Inc.- SUMMARY SCORING				
IMPROVING THE IDENTIFICATION AND MANAGEMENT OF PEDIATRIC OBESITY IN THE 12-17 YEAR OLD MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	M	100	20%	20
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	72.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

WCHP QIP 2: Reducing the Rate of Preterm Births in the NJ Medicaid Population

QIP 2: June 2016 Project Year 1 Update (2) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE RATE OF PRETERM BIRTHS IN THE NJ MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	55
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2016 Project Year 2 Update (1) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE RATE OF PRETERM BIRTHS IN THE NJ MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: June 2017 Project Year 2 Update (2) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE RATE OF PRETERM BIRTHS IN THE NJ MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	70
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 2: October 2017 Project Sustainability Year 3 Update (1) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE RATE OF PRETERM BIRTHS IN THE NJ MEDICAID POPULATION				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	PM	50	15%	7.5
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	57.5
Review Element 10 - Sustainability of Documented Improvement	PM	50	20%	10
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	67.5
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

WCHP QIP 3: Reducing the Proportion of MLTSS HCBS Members 65 Years of Age and Older that Fall

QIP 3: June 2016 Project Baseline Update Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE PROPORTION OF MLTSS HCBS MEMBERS 65 YEARS OF AGE AND OLDER THAT FALL				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	PM	50	10%	5
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	45
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT – Current available points 60			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2016 Project Year 1 Update (1) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE PROPORTION OF MLTSS HCBS MEMBERS 65 YEARS OF AGE AND OLDER THAT FALL				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	PM	50	5%	2.5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: June 2017 Project Year 1 Update (2) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE PROPORTION OF MLTSS HCBS MEMBERS 65 YEARS OF AGE AND OLDER THAT FALL				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	M	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	PM	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	65
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

QIP 3: October 2017 Project Year 2 Update (1) Review

WellCare Health Plans of New Jersey, Inc. - SUMMARY SCORING				
REDUCING THE PROPORTION OF MLTSS HCBS MEMBERS 65 YEARS OF AGE AND OLDER THAT FALL				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	M	100	5%	5
Review Element 2 - Study Question (AIM Statement)	M	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	PM	50	15%	7.5
Review Elements 4/5 - Identified Study Population and Sampling Methods	M	100	10%	10
Review Element 6 - Data Collection Procedures	M	100	10%	10
Review Element 7 - Improvement Strategies (Interventions)	M	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	PM	50	20%	10
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	62.5
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full = 100pts, Partial = 50pts, Non-Compliance = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

WCHP QIP 4: Increasing the Rate of Developmental Screening and Early Intervention in Children 0-3 Years of Age

QIP 4: September 2017 Proposal Review

WellCare Health Plans, Inc. of New Jersey – SUMMARY SCORING				
INCREASING THE RATE OF DEVELOPMENTAL SCREENING AND EARLY INTERVENTION IN CHILDREN 0-3 YEARS OF AGE				
Review Element	Compliance Level	Assigned Points	Weight	Final Point Score
Review Element 1 - Project Topic and Relevance	MET	100	5%	5
Review Element 2 - Study Question (AIM Statement)	MET	100	5%	5
Review Element 3 - Study Variables (Performance Indicators)	MET	100	15%	15
Review Elements 4/5 - Identified Study Population and Sampling Methods	MET	100	10%	10
Review Element 6 - Data Collection Procedures	PARTIAL MET	50	10%	5
Review Element 7 - Improvement Strategies (Interventions)	MET	100	15%	15
Review Elements 8/9 - Interpretation of Results (Demonstrable Improvement) and Validity of Reported Improvement	N/A	N/A	20%	N/A
TOTAL DEMONSTRABLE IMPROVEMENT SCORE			80%	N/A
Review Element 10 - Sustainability of Documented Improvement	N/A	N/A	20%	N/A
TOTAL SUSTAINED IMPROVEMENT SCORE			20%	N/A
OVERALL PROJECT PERFORMANCE SCORE			*100%*	*N/A*
Compliance Level - Full (MET) = 100pts, Partial (PARTIAL MET) = 50pts, Non-Compliance (NOT MET) = 0pts				

COMPLIANCE ASSESSMENT GRID - DEMONSTRABLE IMPROVEMENT			
Score	Range of Points	Level of Compliance	Action
	67-80	1	Requirements MET - Comments, Suggestions
	50-66	2	Requirements PARTIAL MET – Corrective Action Plan
	0-49	3	Requirements NOT MET - Corrective Action Plan

COMPLIANCE ASSESSMENT GRID - COMPLETED PROJECT			
Score	Range of Points	Level of Compliance	Action
	85-100	1	Requirements MET - Comments, Suggestions
	60-84	2	Requirements PARTIAL MET – Corrective Action Plan
	0-59	3	Requirements NOT MET - Corrective Action Plan

WCHP Care Management Audits

WCHP Core Medicaid Care Management Audit

Determination by Category	General Population			DDD			DCP&P		
	2015 (n=100)	2016 (n=98)	% Point Change	2015 (n=21)	2016 (n=21)	% Point Change	2015 (n=34)	2016 (n=20)	% Point Change
Identification	56%	80%	+24	100%	100%	0	100%	100%	0
Outreach	66%	93%	+27	84%	100%	+16	85%	87%	+2
Preventive Services	50%	65%	+15	58%	100%	+42	86%	86%	0
Continuity of Care	99%	99%	0	76%	100%	+24	90%	95%	+5
Coordination of Services	100%	100%	0	93%	100%	+7	99%	98%	-1

WCHP MLTSS HCBS Care Management Audits: July 2014–June 2017

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
#8. Initial Plan of Care established within 30 days of enrollment into MLTSS/HCBS.[1]	Group A&B	25	9	36.0%							
	Group C	28	9	32.1%	13	5	38.5%	10	9	90.0%	51.5
	Group D	48	7	14.6%	86	34	39.5%	90	76	84.4%	44.9
	Group E										
	Total	101	25	24.8%	99	39	39.4%	100	85	85.0%	45.6
#9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary[2]	Group A&B										
	Group C				1	1	100.0%	0	0	N/A	N/A
	Group D				3	3	100.0%	4	3	75.0%	-25.0
	Group E							8	6	75.0%	75.0
	Total				4	4	100.0%	12	9	75.0%	-25.0
#9a. Member's Plan of Care is amended based on change of member condition[3]	Group A&B										
	Group C				2	0	0.0%	2	1	50.0%	50.0
	Group D				8	4	50.0%	8	0	0.0%	-50.0
	Group E							4	0	0.0%	
	Total				10	4	40.0%	14	1	7.1%	-32.9
#10. Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment[4]	Group A&B	25	25	100.0%							
	Group C	24	23	95.8%	9	9	100.0%	7	6	85.7%	-14.3
	Group D	44	42	95.5%	80	79	98.8%	75	69	92.0%	-6.8
	Group E							18	13	72.2%	
	Total	93	90	96.8%	89	88	98.9%	100	88	88.0%	-10.9
#11. Plans of Care developed using "person-centered principles" [5]	Group A&B	26	6	23.1%							
	Group C	27	3	11.1%	13	4	30.8%	7	6	85.7%	54.9
	Group D	44	1	2.3%	86	28	32.6%	75	50	66.7%	34.1
	Group E							18	13	72.2%	
	Total	97	10	10.3%	99	32	32.3%	100	69	69.0%	36.7
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan[6]	Group A&B	20	16	80.0%							
	Group C	24	20	83.3%	10	7	70.0%	5	2	40.0%	-30.0
	Group D	45	34	75.6%	75	65	86.7%	74	56	75.7%	-11.0
	Group E							18	13	72.2%	
	Total	89	70	78.7%	85	72	84.7%	97	71	73.2%	-11.5
#16. Member training on identifying/reporting critical incidents	Group A&B										
	Group C				13	0	0.0%	7	1	14.3%	14.3

Performance Measure		Combined July 2014 – June 2015			July 2015 - June 2016			July 2016 – June 2017			Percentage Point Difference
	Group	D	N	Rate	D	N	Rate	D	N	Rate	
	Group D				86	1	1.2%	75	5	6.7%	5.5
	Group E							18	2	11.1%	
	Total				99	1	1.0%	100	8	8.0%	7.0

[1] From July 2014 – June 2015 and July 2015 – June 2016, compliance with PM #8 was based on establishing an initial POC within 30 days. For the measurement period from July 2016 – June 2017, the criteria for compliance was changed to allow 45 days to establish an initial POC.

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

[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.

[6]Members in CARS are excluded from this measure in review period July 2014-June 2015 and July 2016-July2017.

In July 2015-June 2016, Members in CARS are also excluded from this measure, in addition to any Member who was not receiving any of the following HCBS services that allow the Member to remain in their home: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing

Group A & B – Current Members converted to MLTSS on 7/1/2014. These members were only included in the initial review period.

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